Massachusetts
Health Care Task Force

Final Report

2002

Executive Summary

The Massachusetts Health Care Task Force and the working groups associated with it were created by the highest political leaders in the Commonwealth at a time of extreme uncertainty and financial turmoil in health care. The Task Force and working groups were charged with performing a comprehensive review of the health care system and providing a common basis in fact and understanding upon which state leaders could base policy decisions. For the first time, the top leaders in the state gathered regularly with prominent leaders in health care and other stakeholders to analyze and discuss the complex issues and challenges facing our health care system.

The analysis of the working groups and discussions with the Task Force have helped shape health policy during the last twenty months, resulting in the concrete interventions described in this Final Report. The process has also succeeded in bringing public and private leaders in health care closer together which bodes well for continued thoughtful and informed policy development.

A draft of this Final Report was presented to the Massachusetts Health Care Task Force by its co-chairs and the working groups, whose reports, presentations and deliberations are summarized herein. Task Force members were invited to comment on the draft and some modifications of the draft text were made as a result. In addition, written submissions by Task Force members are included in the appendix of this report (see page 67). Working group reports and other materials presented at Health Care Task Force meetings are assembled in separate a supplementary volume.

This executive summary is a brief overview of some of the main points from the Final Report. It is not a summary of all the issues, observations and recommendations in the body of the Final Report or of the working group reports themselves, which cover a wide variety of issues relating to health care.

Because the working groups and the Task Force were convened by state government, they have focused on state government policies and interventions. Because of the close inter-relationship between public and private actors in the health care system, the actions of one group affect system conditions and actions by the other group. Interventions designed to address a particular issue may have unforeseen negative effects on other issues or on other actors within the system. Continuous monitoring, collaboration and re-evaluation of policies will continue to be necessary.

The System as a Whole

The rapid rate of increase in health insurance premiums and health care costs in recent years is a significant problem for the continued viability of the Massachusetts health care system. Although revenue flowing into the system has increased, and many payers and some providers are more financially stable than they were, conditions have not improved for all. Patient care costs are increasing almost as fast as revenues, and in some sectors, limited availability of funds has made the situation much worse. Further, if premiums continue to increase at the current pace, many employers, consumers, and the state will have trouble paying for health care coverage resulting in the potential for significant additions to the ranks of the uninsured.

Health care cost increases result from a variety of forces. New drugs and technol-

ogy are continually being incorporated into treatment and care plans, often at significant increased cost. There appears to be little systematic evaluation of the added costs and added benefits of new technologies and drugs.

In addition, in some areas, patient volume has been shifting towards more expensive settings such as teaching hospitals, hospital outpatient departments, and hospital emergency departments (EDs), and away from comparatively less expensive settings such as community hospitals and community-based physician offices. This trend contributes to the financial distress among some community hospitals and increases the spending levels for Medicaid and other payers.

Concerted and collaborative public and private efforts to encourage a greater percentage of care to be provided at a lower cost and at clinically appropriate sites of care would help constrain the rate of health care cost increases for both the state and private payers, and should be actively pursued. In addition, wherever possible, unnecessary expenses in the system should be identified and eliminated. Examples of areas for public and private action and planning include:

- Economic incentives for providers and consumers to incorporate cost-consciousness into their decisions about care;

- Comparative data analysis and reporting on cost, quality and efficiency of providers;

- Quality improvement initiatives, which will also improve cost-effectiveness of care; and

- Administrative simplification, including collaborative HIPAA compliance strategies as well as coordination and streamlining of government-imposed regulatory complexity.

Increasing Revenue to Support the System

Controlling cost increases is an important goal, but more will be required to restore financial stability to the system. It is likely that more revenue flowing into the system will be needed. The question of how much of that additional revenue should come from employers through health insurance premiums, from consumers through cost-sharing, and from the state through higher Medicaid payments or other means, will require continuous monitoring and adjustment, since increases in payment from any sector will have effects on other issues.

- The Finance Working Group has recommended that the Medicaid program increase its rates to hospitals and nursing homes. But if those rate increases come at the expense of other important areas of state spending, possibly even Medicaid enrollment, the net result for providers might not be positive.

- Similarly, private payers in Massachusetts have paid less in relation to costs than in any other state in recent years. Although hard data on more recent private payment rates are not yet available, the trend in the last two years appears to have reversed as double-digit premium increases have become the norm. While Massachusetts HMOs and some providers appear to have improved their financial positions as a result, some providers have seen less of an impact. Available resources for continued rate increases are limited as corporate profits continue to be low. In the face of further increases, employers may reduce or drop coverage and are likely to shift costs to consumers.

- As consumers face increasing out-of-pocket costs, they may be unable to afford insurance coverage and numbers of uninsured may rise. That would result in

decreased access to services and increased financial pressure on providers and on the Uncompensated Care Pool.

Recognizing these inter-relationships, the Finance Working Group recommended that the state pursue a multi-pronged strategy that combines rate increases necessary to recognize an appropriate proportion of provider costs; adjustments to the Medicaid payment formulas to more appropriately reflect current conditions; targeted assistance to sustain needed providers in the short term; increased regulatory authority in the insurance arena; and increased monitoring of financial conditions and trends in the system as a whole.

The Access Working Group recommended that the state encourage flexibility in insurance product design to avoid losing private sector coverage in the face of cost increases.

Increasing Monitoring and Reporting

More than revenue increases, however, will be required to maintain a viable system. State government has been increasing its involvement in and engagement with the health care financing and delivery systems, and must continue to do so. As controlling aggregate health care cost increases becomes imperative for the private sector as well as Medicaid, the state can play a more central role in helping to create a balanced and efficient health care system.

As the state explores the appropriate level of involvement in this arena, an important consideration is the role that the health care system plays in driving our state economy. Achieving and maintaining the right level of state involvement will require continuous monitoring and evaluation.

Recommendations for increased government activity with respect to health care include:

- Increased monitoring and reporting on financial conditions in the health care system, including conditions of payers and providers;
- Increased regulatory authority in the insurance arena;
- Development of measures and reporting on quality of care, cost and efficiency at the provider-specific level; and
- Collaborative work with the private sector to develop quality improvement initiatives.

In addition, state government may need to provide targeted financial support to providers who are needed to preserve access to essential services or who have the potential to offer lower-cost alternative care settings that are important for keeping the system more affordable. This strategy has been recommended by the Finance Working Group and others, and has been pursued over the course of the last two years. It may be appropriate to combine such assistance with increased involvement in the system overall. Although the Finance Working Group recommended this kind of government involvement, it also recommended that over time, reasonable and fair payment by all payers and appropriate use of lower-cost care settings should be sufficient to sustain the delivery system.

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PRESS RELEASE

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Cellucci, Swift, Birmingham, Finneran, Lees, Marini Convene Health Care Task Force

Governor Paul Cellucci, Lieutenant Governor Jane Swift, Senate President Thomas F. Birmingham, House Speaker Thomas M. Finneran, Senate Minority Leader Brian Lees and House Minority Leader Francis Marini Today announced they have convened a statewide task force to conduct a comprehensive analysis of the health care industry in Massachusetts. The task force will examine all areas of health care in the Commonwealth, including operation, administration, access, regulation, financing, revenues, cost, liabilities, reserves, financial viability, delivery, outcome and quality.

"Massachusetts has always been a world medical leader and the effort we are announcing today is designed to make sure Massachusetts protects its reputation as a health care leader," said Cellucci. "Not only must we ensure our citizens continue to have access to the highest quality health care, we need to take steps to protect this very important sector of our economy which employs thousands of Bay State residents."

"The health care industry is multi-faceted and there are many different perspectives and interests that need to be addressed," said Swift. " The only way to tackle an issue of this complexity and sensitivity is to deal with it comprehensively with all sides at the table and all viewpoints represented."

The task force, which will be co-chaired by former Supreme Judicial Court Chief Justice Herbert Wilkins and Brandeis Professor Stuart Altman, will report back to the state's legislative leadership with its findings and recommendations. The group will include representatives from throughout the health care community, including hospitals, health maintenance organizations, extended care facilities, health care providers and consumer advocates. The group will also include representatives of business, labor, and government.

"Patients are sick of the chaotic state of our health care system," said Birmingham. "We hope that by bringing together health care providers with consumers and the political leadership of the state, we can begin to develop a coherent and effective system to deliver high-quality affordable health care to the people of Massachusetts. Our ability to provide access to high-quality health care is one measure of whether or not we earn the title 'Commonwealth'."

"It is imperative that a thorough examination of our health care system—its current strengths and weaknesses as well as the challenges and opportunities which looms ahead—be held by well-informed principals. I am confident that the individuals on the task force, under the guidance and direction of Professor Altman and Judge Wilkins will rise

to the demands of responsible leadership dictated by this issues," said Finneran. "It is probably the most important collective undertaking we could initiate and I am delighted that we will be led by two individuals of such intellect and renown."

Judge Wilkins will preside at all task force meetings and direct the administration and procedures of the task force. Professor Altman will oversee four existing working groups currently examining the areas of health care finance, access, quality and administrative simplification. These working groups will present conclusive data and policy options to the task force for examination and debate. Wilkins and Altman may create other working groups if it is deemed necessary.

"The members of this task force have various perspectives, but they share a common commitment to health care," said Wilkins. "We can all be hopeful that this effort will help government and community leaders to define the issues, to structure meaningful dialogue and to identify possible solutions."

"This is a good time to take a look at our health care system in as comprehensive a manner as possible," said Altman. "This task force presents an opportunity for knowledgeable people from different perspectives to review data, exchange views and strategize about possible solutions to some of the challenges facing leaders in government and in health care."

The task force is expected to begin meeting later this month and will present an interim report of findings and recommendations by the end of the year. A final report will be issued by the end of the year 2001.

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Summary of Recommendations

Overall Recommendations

1. *Collaborate with Payers and Providers.*
   As the government pursues new policies and intervention strategies, it should work collaboratively with payers and providers to increase planning, and to design and implement quality initiatives and economic incentives.

2. *Redistribute Care to Lower-cost Settings.*
   The Medicaid program and managed care plans should continue to make efforts to direct patients to lower-cost settings. To assist with this effort, the state should encourage the development of capacity among lower-cost community-based providers such as physician offices and community health centers.

3. *Consider Increased Government Regulation and Planning.*
   Areas for potential increased regulation include: permissible provider service mixes, provider relationships, rate regulation, intervention with "at risk" providers, and receivership.

4. *Explore Quality-Based Initiatives.*
   Quality initiatives should be pursued at all levels of care to reduce error and to increase care effectiveness, particularly among lower-cost providers in order to support cost-conscious consumer choices.

5. *Explore Economic Incentives.*
   Engaging consumers and providers through incentives may be successful in constraining, to a degree, the rate of cost increases.

6. *Increase Monitoring.*
   Increase timely data reporting about financial conditions and service use in the health care system and increase state monitoring of trends and conditions.

Access Recommendations

The Access Group suggested pursuing several strategies at the same time because no single approach would succeed in making adequate and affordable insurance available to all residents. Among the strategies it recommended for exploration, along with financial analysis and additional information, were the following:

1. *Consider Expanding MassHealth.*
   If groups of people who lack insurance can be identified by common characteristics, consider expanding MassHealth eligibility by income level or category, if fiscally possible.

2. *Combine and Streamline State Programs.*
   Wherever possible, combine and streamline programs and processes to reduce administrative complexity and confusion.

3. *Consider Alternative Insurance Product Design and Rate Regulation.*
   Consider whether high-deductible policies with subsidies to help low-income enrollees meet those deductibles, or other changes to permissible product design, could make health insurance more affordable. Also consider revising rate banding requirements to maintain affordability.

4. *Consider Using Tax Credits and Subsidies.*
   Additional forms of subsidies or tax credits to employers, employees, or both, for the purchase of commercial insurance could result in more people obtaining coverage.

5. *Consider Mandating Insurance Coverage.* Mandates on employers to offer insurance coverage, or on individuals to obtain and maintain insurance coverage, should be explored. Consider "indirect mandates" requiring all entities that contract with the Commonwealth to provide health insurance to their employees.

6. *Educate Employers About Tax Advantages.* In particular, educate employers about the tax advantages of paying for health care through medical savings accounts and flexible spending accounts.

7. *Exercise Caution on Mandated Benefits.* Assess the financial impact of proposed new mandated benefits before enacting mandates.

Quality Recommendations

The Task Force heard three sets of recommendations on improving quality of care. There is some tension between recommendations that stress the publication of provider-level quality and medical error information, and those that stress confidentiality for individual providers and focus on systems improvement. The recently created Betsy Lehman Center for Patient Safety and Medical Error Reduction will provide the Commonwealth with a forum for resolving those tensions and for pursuing quality improvement initiatives in health care.

Recommendations from the Quality Working Group

1. Align state policies and practices to foster quality improvement and error reduction.

2. Expand and improve data collection and reporting on quality and medical errors, especially in non-acute settings and at the provider-specific level.

3. Develop and implement evidence-based practice guidelines.

4. Design financial incentives to encourage patient-centered quality improvement.

5. Expand and coordinate state efforts in consumer education about quality of care.

Recommendations from Lucian Leape of the Harvard School of Public Health and the Institute of Medicine's Report: "To Err is Human"

1. Health care professionals should follow best practices, identify and change unsafe systems, and take responsibility for problematic individual practitioners.

2. Hospitals and health care organization CEOs should take responsibility for patient safety, because safety is primarily a function of systems.

3. Safety should be part of any health care organization's strategic plan; punishment of individuals for errors should be avoided; systems should be changed to reduce burdensome workloads and to increase accuracy.

4. Regulatory policy should focus on safe practices and standards, and move away from focusing on individuals, blaming and punishment.

Recommendations from the Leapfrog Group

This employer group focuses on specific and easily verifiable measures associated with better outcomes in hospital care. As a way of improving quality of care and reducing costs associated with errors or suboptimal care, its members adopt policies designed to steer patients toward hospitals that:

1. Employ specially-trained intensivists in their intensive care units.

2. Perform more than a threshold number of certain complex procedures each year.

3. Have implemented computerized prescription order entry systems.

Administrative Simplification Recommendations

1. *Focus on Government's Role as Convenor and Facilitator.*
   The Commonwealth of Massachusetts should act as convenor of public and private health care actors and as facilitator for discussion of common approaches to simplification, rather than impose regulation as a means of forcing simplification in a particular manner.

2. *Leverage HIPAA Compliance Efforts.*
   Use HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance planning and investment to achieve broader administrative simplification.

3. *Leverage Existing Collaborations.*
   The Commonwealth should rely on and work in collaboration with the Massachusetts Health Data Consortium in coordinating private and public sector HIPAA compliance and administrative simplification efforts.

4. *Report on HIPAA Compliance Progress.*
   The Commonwealth should request health care system participants to submit information periodically showing their progress toward HIPAA compliance and administrative simplification. The Commonwealth should consider forming a high-level review panel of government and business leaders to review and evaluate those reports and to encourage continued focus on administrative simplification.

5. *Develop Industry Administrative Performance Standards.*
   With the Massachusetts Health Data Consortium, develop performance standards for administrative functions, and request that payers, providers and employers report periodically on the extent to which they meet those standards.

6. *Support Demonstration Projects and Centers of Excellence.*
   The Commonwealth should support experimentation and creativity in the development of administrative simplification approaches through demonstration projects and centers of excellence.

7. *Focus on Small Providers.*
   The Commonwealth should focus on developing technology that will help smaller providers and should encourage use of existing technology, including the Internet, among smaller providers.

8. *Review and Simplify State Administrative Requirements.*
   The Commonwealth should evaluate, coordinate and simplify the administrative burdens it imposes on health care sector participants in order to avoid unnecessary administrative complexity and paperwork.

Finance Recommendations: Hospitals

1. *Increase State Funding for Hospitals.*
   The Finance Working Group supports increasing state funding for hospitals through an overall relief plan. The plan should use the following principles to guide decisions about how to distribute increased funding:

   - Fair Payment: Medicaid payment for a particular service should cover a reasonable percentage of the necessary cost of efficiently delivering that service.

- Medicaid Access Preservation: The state's Medicaid policy should work to ensure reasonable access to services for and by Medicaid enrollees.

- System Stability: The state should work to preserve and stabilize those hospitals and services necessary to protect the health of all Massachusetts residents.

2. *Adjust Medicaid Rates.*
   Medicaid rates should be increased and the state's payment-to-cost ratio should be improved to levels closer to what is paid in other comparable states. This effort would involve evaluation of several components affecting payment level:

   - Medicaid Payment Formula. The Medicaid program must ensure that its payment formula results in a "fair payment" level, as defined above.

   - Update factor. The Medicaid formulas should include an update factor that appropriately reflects unavoidable increases in the necessary costs incurred by hospitals, as well as a component that maintains an incentive for efficiency and good management.

   - Hospital Costs and Cost Allocation. Further study is needed of hospital costs, cost allocation methods, and the share of costs of efficient hospitals that should be covered by Medicaid.

3. *Evaluate Uncompensated Care Pool Reform.*
   Evaluate the Uncompensated Care Pool's funding and payment systems, with attention to the effect that various changes would have on each hospital.

4. *Continue Distressed Hospital Funding.*
   In the short term, grants to prevent certain distressed hospitals from closing or closing needed services may be required.

5. *Increase Frequency of Financial Reporting.*
   Require hospitals (and other providers) to submit financial data more frequently, and increase the state's analysis and monitoring of the system.

6. *Shift Patient Volume to Appropriate Lower Cost Providers Where Possible.*
   Particularly in those areas in which volume has shifted away from lower-cost community providers, develop ways to encourage the provision of more care in clinically appropriate lower-cost settings and providers.

Finance Recommendations: Nursing Facilities

1. *Study Medicaid Payment Formula.*
   The state Medicaid program has been moving toward a standard Medicaid rate system based on statewide average recognized costs rather than on facility-specific reported costs. The state should continue using this pricing approach, provided that standard prices are set at a level that is high enough to provide revenue sufficient to maintain an efficient, well-run facility that provides safe, adequate and dignified care for Medicaid patients. To ensure the reasonableness of Medicaid payments, the Commonwealth should undertake focused study of:

   - Medicaid Allowable Costs. Medicaid should not pay for additional costs that some facilities may have incurred investing in more expensive services used primarily by Medicare patients or higher-end amenities to attract privately paying residents.

   - Medicaid Payment Formula Adjustment. Medicaid officials should re-examine certain features of the rate-setting method and of the method being used for transitioning from facility-specific, cost-based rates to the standard rates.

- Medicaid Update Factor. Medicaid program officials should review the factor used to adjust costs from the base year to the rate year. However, substantial Medicaid rate increases across the board or increases that raise rates disproportionately for high-cost facilities are not recommended.

- Further Study. Further study should be conducted to determine whether the standard rates the current system yields are adequate to cover necessary costs, as well as whether the rate-setting formula can be modified to include incentives for high-quality care and efficiency.

2. *Consider Targeted Financial Assistance.*
   In the short term, special assistance for particular facilities may be necessary to preserve efficient and high-quality facilities.

3. *Explore Increasing Private Resources.*
   For example, if family members were permitted to supplement Medicaid payments to obtain certain amenities for a nursing home resident, or if private long-term care insurance were more prevalent, facilities would have access to additional revenue sources.

4. *Increase Coordinated Monitoring and Policy Making.*
   Increase and coordinate regular monitoring of nursing home financial conditions, occupancy rates, and service availability. Agencies that regulate various aspects of the nursing home industry should work more closely together to coordinate policy.

5. *Provide Technical Assistance.*
   Identify best practices of efficient, low-cost and high-quality facilities.

6. *Continue Workforce Initiatives.*
   Support the development of career ladders and continue wage pass-through funding for direct care workers.

7. *Increase Long-term Planning.*
   In the longer term, it will be essential to identify and support more innovative and promising methods of organizing and providing long-term care, focusing on developing a cost-effective and high-quality community-based continuum of care.

Finance Recommendations: Community Health Centers (CHCs)

1. *Maximize Efficient Use of CHCs.*
   Explore whether CHCs can offer a lower-cost alternative setting for some of the care now being provided in hospital outpatient and EDs, and facilitate the shift of patients from hospitals to CHCs where geographically and clinically appropriate.

2. *Review Adequacy of Public Payments.*
   Medicaid rates and other public payments (e.g., from the Massachusetts Department of Public Health) should be reviewed for appropriateness.

3. *Coordinate and Streamline Administrative Requirements.*
   Review and coordinate across agencies the contract, billing and reporting requirements that apply to CHCs.

4. *Explore Workforce Initiatives and Technical Support.*
   To the extent resources are available, support creation of a State Health Service Corps to help CHCs attract and retain quality staff (including tuition assistance and loan repayment opportunities); technical assistance and upgrading of CHC systems. Provide grants or low-interest loans for urgent needs, deficits and possible expansion.

Finance Recommendations: Home Health Agencies

1. *Review Medicaid Rates and Service Eligibility Rules.*

This review should be part of broader long-term care planning efforts aimed at increasing effective community-based care options.

2. *Explore Alternative Relationships with High-Volume Providers.*
   Medicaid program officials should explore the use of special contractual arrangements between the Medicaid Program and high-volume providers using alternative reimbursement systems, such as prospective payment.

3. *Use Grants or Loans to Assist with Specific Capital Investments.*
   To the extent funds are available, relatively small grants or loans could allow home health agencies to make capital investments —such as the purchase of portable computers and telemedicine equipment—that would increase their overall effectiveness.

4. *Encourage Innovation in Community-Based Care.*
   Authorize pilot programs and demonstration projects that use different models of care to determine which policies and structures work best at the community level.

5. *Coordinate Services and Eligibility Rules.*
   State funded and administered programs should coordinate so that eligibility rules and funding streams do not create barriers to service plans that are the most efficient and cost-effective way of meeting people's needs.

Finance Recommendations: Physicians

1. *Consider Targeted Medicaid Rate Increases.*
   While funding is scarce, Medicaid program officials should consider rate increases for services and providers used most by Medicaid patients and for those providers who practice in low-cost settings.

2. *Assist Physicians with Administrative Simplification.*
   The state should collaborate with physicians to achieve administrative simplification through HIPAA compliance and in the Medicaid program in general.

3. *Explore New Capitation Models.*
   New models of integrating physician responsibility for resource use and financing should be explored, but must include sufficient payment rates and adequate data to support quality and effective management of care.

4. *Increase Monitoring.*
   As with other sectors, data about physician practice, costs and practice patterns should be collected and monitored.

Finance Recommendations: Workforce

Resolution of workforce issues requires solutions that reach beyond the health care sector to involve the academic community, labor unions, and public schools. The state should pursue planning and innovation in several different areas simultaneously, and in collaboration with academic and provider groups, to alleviate workforce shortages over the near and longer term.

1. *Develop Educational Programs and Incentives.*
   For example, design new training programs at multiple levels of professional development, and increase financial supports and incentives such as loan forgiveness programs for workers who devote time to underserved communities.

2. *Improve Working Conditions for Health Care Providers.*
   For example, ensure reasonable workloads and demands for direct care provider positions, and reduce unnecessary paperwork.

3. *Allocate Tasks Among Available Workers to Ensure Patient Safety and Quality of Care.*

In some cases, there may be opportunities to assign certain tasks to different levels of professionals without reducing quality of care.

Finance Recommendations: Prescription Drugs

Ultimately, intervention from the federal government will probably be required to achieve significant savings on prescription drugs. Even so, the state should explore options that may improve affordability of and access to prescription drugs, including options that would involve fundamental changes to the current system.

1. *Explore State-Level Price Controls.*

2. *Consider Establishing a State Wholesale Drug Purchaser.*
   This entity would purchase drugs at reduced rates for all residents and health plans.

3. *Explore the Creation of a Single-payer Type of Insurance Plan for Prescription Drugs.*
   Participation by health plans would be required, clearly changing the structure of current health plans.

Finance Recommendations: HMOs/Insurers/Payers

1. *Enact legislation establishing minimum net worth and risk-based capital requirements consistent with national standards.*

2. *Require More Detail and Broader Scope in Financial Reporting.*
   Specifically, require plans to report financial results by line of business, to file reports using statutory accounting rules as well as Generally Accepted Accounting Principles, and to report on ASO (Administrative Services Only) business and enrollment.

3. *Consider Increasing Oversight of Risk-sharing Arrangements and Risk-bearing Entities.*
   Additional oversight would help ensure that providers who assume risk have the operational capability and the financial resources to manage the risk assumed and that the financial terms of the arrangement are reasonable.

4. *Assess the Likely Financial Impact of New Mandated Benefits Prior to Enactment.*
   While there is disagreement about the extent to which mandated benefits increase insurance premiums, there is support for requiring a cost analysis before expanding mandates.

5. *Increase Oversight of Major Transactions.*
   Enact legislation giving the Commissioner of Insurance authority to oversee certain major transactions of HMOs, such as sales of substantial assets, mergers, and expansion into other states.

6. *Require Actuarially Sound Premiums.*
   Explore the possibility of requiring that premiums be certified by an independent analyst as being sufficient to cover the benefits to be provided.

Recommendations for the Future

There should be an ongoing group whose mission transcends that of any existing agency in health care and whose members include people from the private sector. An ongoing public-private analytic effort would provide a structure and framework for continued analysis and communication as the state re-assesses its role with respect to regulation of and intervention in the private health care system and protection of the health care safety net.

I: Introduction

State leaders[1] created the Health Care Task Force in the late spring of 2000, shortly after the receivership of Harvard Pilgrim Health Care and in the midst of widespread reports of hospital financial distress. Through the Task Force and its associated working groups, they hoped to learn more about the paradox that has vexed the Massachusetts health care system for at least several years: Despite the fact that Massachusetts health care expenditures per capita are considerably higher than the national average and higher than those of other states, prominent participants in the health care system—including our largest health maintenance organizations and hospitals—were in financial trouble.

The Task Force convenors had these common goals:

- to preserve access to the highest quality care for Massachusetts residents;
- to preserve and stabilize the health care sector of the state's economy;
- to maintain Massachusetts' position as a health care leader; and
- to create greater confidence in the system among residents and businesses.

The Task Force's mandate was:

- to conduct a comprehensive analysis of the health care system in Massachusetts;
- to find facts about the current state of our health care system;
- to identify problems or weaknesses in the system;
- to advance possible solutions to identified problems for consideration by executive and legislative leaders; and
- to provide a forum for discussing identified problems and possible solutions among health care experts and professionals in which differing views and opinions could be expressed.

Consistent with the concern about financial stability that led to its creation, the Task Force has focused particular attention on financial issues. Most meetings of the Task Force included reports from one or more of the working groups. These reports were designed to present the most up-to-date information on the subject under review and, where appropriate, the advantages and disadvantages of various options for intervention.[2] In some cases, the working groups presented their recommendations on a preferred strategy for action.

The reports, presentations and discussions at Task Force meetings revealed the complex interrelationship of many challenges that confront the patient, the provider, the insurer, the employer and the government. Many identified problems are beyond resolution by state government action alone. Some are beyond short-term solution by any single actor. Others can be alleviated, in the short or long-term, by either government or private sector action, or some combination of the two.

Because the Task Force was created to assist state government leaders, the working group reports often focused on options for state action, as opposed to private sector actions. The inter-relationship between government and the private sector in health care, however, required that the Task Force

consider the effect of actions by one group on the other. For example, one reason that Medicaid hospital payment rates were such a prominent theme during Task Force deliberations is that in Massachusetts, unlike in other states, private payers were no longer paying a margin above costs. Thus, private sector payment policy in combination with state payment policy and changes in federal Medicare payment policy contributed to the financial instability among hospitals, which in turn contributed to the decision by state leaders to convene the Task Force.

One concern about advancing proposals for state government action is that various factors bearing on a particular problem are constantly changing, and a policy change in one area may have unforeseen or undesirable effects in others. The question then is whether a proposed action, even if it improves the particular problem it is intended to alleviate, would in fact improve the delivery of health care overall in the Commonwealth.

For example, increasing Medicaid provider payment rates across the board might help to alleviate the financial stress of some providers, but finding the funds to implement substantial increases at this time might require cuts in state spending in other areas—even in Medicaid eligibility. If the number of uninsured residents were to rise substantially (due to program cuts, employer benefit cuts, or both), uncompensated care would likely become a more prominent source of losses at the provider level, and some providers might see no net gain in their financial position even if Medicaid rates were increased.

In addition, substantially increasing Medicaid provider payments might enable private payers, who, as noted, have reportedly paid hospitals less on average in relation to their costs than in any other state (see Figure 10 on page 27), to forestall further increases in their payment rates. While this might have a positive effect on the rate of premium increases and insurer financial stability, it would also increase the share of the system supported by state payments and decrease the share supported by private payments.

An argument can be made that, if the state were to accept a greater role in financing hospitals through Medicaid, then, in order to protect taxpayers, it should also take a greater role in monitoring or regulating the costs hospitals incur. Whether that result would amount to a net gain for the health care system, for the state's economy, or both, and whether it would lead to further changes, such as increased state regulation of health care or increased state revenue to support health care, depends on political, social and general economic considerations well beyond the mandate of the Health Care Task Force.

This Final Report, which is a summary of the working group deliberations and comments from Task Force members, is submitted with the hope that it will assist state leaders in making assessments and decisions about health care policy. The report begins with a description of the structure and procedures of the Task Force and working groups, an overview of changes in circumstances over the course of the Task Force's proceedings and a discussion about the context in which the working groups' analyses of particular issues should be viewed.

The second section of the report discusses the health care system as a whole and issues related to the system, including a summary of reports by the Working Groups on Access, Quality and Administrative Simplification. The third section presents a summary of the reports and recommendations prepared by the Finance Working Group and its analysis of particular sectors of the health care system.

Because hospitals are such a significant part of our health care system and because several of the system trends observed relate to hospital utilization, there is some overlap

between the discussion in Section II and the discussion of hospitals in Section III. The Report concludes with reflections on the Task Force process itself and recommendations for future state analyses of the health care system.

Task Force Structure and Procedures

The Task Force was convened jointly by then-Governor Paul Cellucci, then-Lieutenant Governor Jane Swift, Speaker of the House of Representatives Thomas Finneran, and Senate President Thomas Birmingham. No legislation or executive order memorialized the creation of the Task Force, and no detailed mandate was issued. These leaders simply agreed that a concentrated examination of the Commonwealth's health care system was needed to help them understand, from a shared factual basis, the conditions, forces and trends at work, so that they would be better positioned to determine what actions or interventions would be appropriate.

They asked Professor Stuart Altman of Brandeis University to serve as Co-Chair and to guide the substantive analysis, and Justice Herbert Wilkins, retired Chief Justice of the Massachusetts Supreme Judicial Court, to serve as Co-Chair and to guide the procedure for discussion and analysis. With the agreement of the Co-Chairs, the convenors asked a number of health care leaders and other interested parties to participate in the effort, and announced the undertaking in a joint press conference on May 1, 2000.

Four working groups focused on subsets of issues were forming at approximately the same time under the direction of William O'Leary, then Secretary of Health and Human Services, and Jennifer Davis Carey, Director of the Office of Consumer Affairs and Business Regulation. Those groups were the Finance Working Group, the Access Working Group, the Quality Working Group, and the Administrative Simplification Working Group. Each group presented its findings, analysis of policy options, and where possible, recommendations to the Task Force for discussion. Several guest presentations supplemented the findings and views of the working groups and added to the Task Force's discussions.

The Task Force Co-Chairs and convenors agreed at the outset that because of its size and the structure of its membership, which was heavily weighted towards teaching hospital and HMO leaders, the Task Force itself would take no votes or official "positions." Instead, it would act as a sounding board and forum for discussion of the data, analysis and options reported by the working groups.

The Task Force convenors requested an Interim Report at the end of 2000 and a Final Report at the end of 2001. In January 2001, the Task Force Co-Chairs submitted an Interim Report outlining the working group reports that had been presented to the Task Force as of that date. These reports listed areas that the working groups and Task Force Co-Chairs intended to undertake during the remainder of the Task Force's allotted time, and posed several over-arching questions that underlie much of the analysis and discussion of health care in the working groups and the Task Force.

This Final Report follows a similar approach. It summarizes the material presented by the working groups to the Task Force throughout its proceedings, and attempts to place that material into a context that has changed dramatically since the initiation of the Task Force. The Finance Working Group, co-chaired by Professor Altman and Secretary O'Leary, until his departure in October, and by Secretary Robert Gittens since that time, has been the guiding force behind much of the Task Force presentations and discussions, and has assisted in distilling many observations in this Final Report.

Task Force Overview: 2000-2002

Since the work of the Task Force began in early 2000, there have been changes in the relative financial positions of stakeholders in the system. There is reason to hope that our system is more financially stable than it was when our inquiry began, but the potential for continued financial distress and instability remains. Massachusetts HMOs, one of which was in receivership and several others of which were teetering on the brink of insolvency in early 2000, appear to be in stronger financial shape (see Figure 41 on page 60).

Some hospitals have improved their financial positions, but others are still struggling and may be losing ground (see Figure 11 on page 28). The nursing home industry is still in financial distress, though some national nursing home chains that had entered bankruptcy proceedings during the last two years are working their way through restructuring with the hope of emerging with more manageable debt burdens and cost structures (see Figure 21 on page 41 and Figure 22 on page 42). Home heath care providers have seen some relief under the Medicare prospective payment system, but they continue to struggle financially and face the prospect of more Medicare cuts, with no meaningful relief from other payers. Employers, who in early 2000 were just coming out of a period in which health care cost increases had been small for a number of years, have now seen several years of significant annual increases in premiums, with no relief in sight[3] (see Figure 1 below).

Over the course of its proceedings, the Task Force was presented with and discussed several recommendations and policy options that have led directly or indirectly to state actions or other developments affecting the health care system. For example:

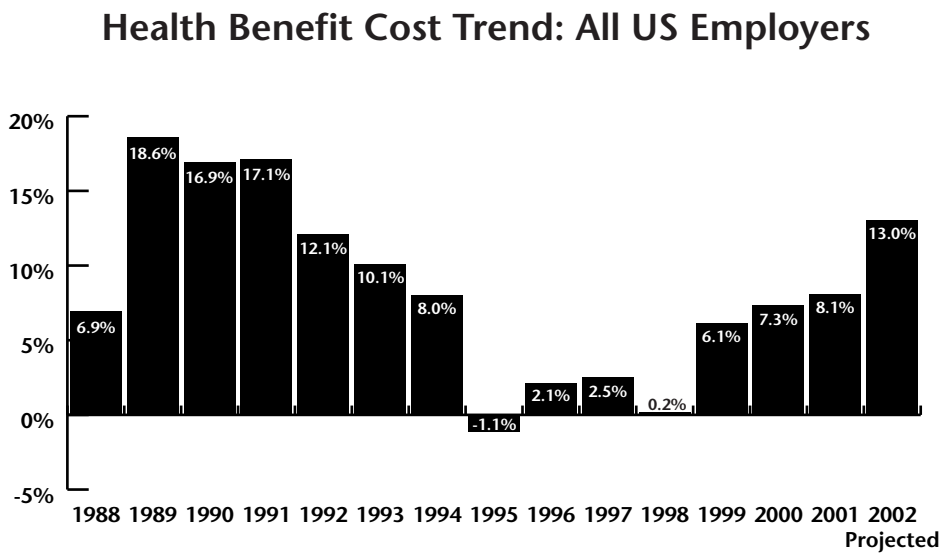

Figure 1

Employer health care costs increased rapidly in the early 1990s, leveled off in the middle of the decade, and started to rise again at the end of the decade.

Source: William M. Mercer, Incorporated

- In July 2000, the Task Force discussed the serious financial conditions of nursing homes and their particular problems attracting and retaining direct care workers. Shortly thereafter, the state devoted significant additional dollars to Medicaid nursing home rates, set aside resources for wage increases to certified nursing assistants and created several programs to improve training and career ladder opportunities for direct care workers.[4]

- In October 2000, the Finance Working Group outlined its recommendation for financial assistance for hospitals, including Medicaid rate increases and targeted relief for hospitals in particular financial distress. The state budget, passed in November 2001, included both of these elements.[5]

- In March 2001, the Finance Working Group analyzed forces exacerbating financial distress at Whidden Hospital in Everett as an example of urban community hospital distress. This analysis, and the Task Force's discussion of it, supported state leaders who facilitated a resolution that preserved the hospital and critical mental health services.

- In several meetings, the Finance Working Group stressed the importance of collecting and analyzing financial and utilization information more frequently in order to identify, as early as possible, financial trends, and health plans and institutions facing particularly difficult financial situations. The FY02 state budget includes a provision granting the Division of Health Care Finance and Policy express authority to collect certain information on a quarterly basis.

- The Administrative Simplification Working Group recommended that the state develop a statewide HIPAA compliance strategy and that it work collaboratively with the private sector around HIPAA compliance issues through the Massachusetts Health Data Consortium. In 2001, the Commonwealth created a HIPAA Program Management Office in the Executive Office of Health and Human Services to coordinate agency compliance efforts and to interface with the Massachusetts Health Data Consortium, the principal forum for private sector collaboration around HIPAA and many other issues.

- The Quality Working Group recommended that the Commonwealth coordinate its policies and procedures pertaining to medical-error reporting and that it develop and disseminate evidence-based best practice guidelines. The FY02 state budget created the Betsy Lehman Center for Patient Safety and Medical Error Reduction to fulfill these and other related functions.

- In several reports and discussions, the Finance Working Group observed that consumer incentives could play an important role in tempering the trend of increasing utilization of high-cost teaching hospitals for services that could be provided in clinically appropriate lower-cost settings. The introduction of products that require higher copayments for services at teaching hospitals than for services at community hospitals could be seen as consistent with this observation, although some of those products appear to be focused on cost-shifting rather than tailored to encourage medically appropriate utilization of teaching hospitals and other settings.

Despite some evidence of increasing financial stability, the increase in dollars flowing into the system through higher premiums and copayments appears to be having a greater impact on employers and

consumers, who are concerned about cost increases, than it is having on providers, whose financial positions have not (with certain exceptions) improved substantially.[6] Employers are balking at the prospect of continued significant annual premium increases and are questioning whether the mergers and provider re-alignments of the 1990s yielded any cost efficiencies, or whether they may have increased costs or masked financial troubles. There is now little available revenue to add to the system from public sources, as the state faces significant revenue shortfalls. Also, private funds are increasingly limited, as the economy continues to be sluggish. Still, health care costs continue to rise.[7]

These facts become more troubling in light of the new priority our nation and our Commonwealth must place on public safety. Inevitably, choices will have to be made about allocating resources among competing worthy goals and programs. Even more than might have been the case before September 11, 2001, the situation calls for public and private efforts to reduce the rate of health care cost increases. Forces affecting overall cost increases and possible interventions to counteract the trend are discussed in "The Massachusetts Health Care System" beginning on page 9.

Context: Hospitals, Medicaid and State Policy Priorities

The Task Force and the Finance Working Group spent much of their time studying and discussing hospitals, and within that discussion, devoted particular focus to Medicaid payments to hospitals. The focus on hospitals is appropriate because everyone has the potential to need hospital care and has an interest in preserving access to high-quality hospitals. Further, hospital care accounts for the largest single expense covered by our health insurance premiums. Many Massachusetts hospitals have been in serious financial distress; maintaining our world-class hospitals is important to our state identity and to our state economy. The focus on Medicaid rates also has been appropriate. The Medicaid rate is one of the most significant vehicles in the state's control to influence financial conditions of hospitals.

These discussions, however, must be put into the context of the health care system overall, the goals and limitations of the Medicaid program, and the state's general position with respect to revenue and expenses. For example, the role of Medicaid in long-term care is larger, both in terms of dollars expended and in terms of its relative importance as a payer, than the role of Medicaid in the hospital system.[8]

Massachusetts' nursing homes, in the aggregate, appear to be in at least as much financial distress as the hospitals, and their potential sources of additional revenue are more limited. Publicly financed long-term care, currently concentrated in nursing homes, is of the utmost importance to those who need it. For most of these people—largely the poor elderly and people with disabilities—no alternative to nursing home care is readily available at this time.

The role of Medicaid in ensuring access to primary and preventive services is also critically important. Massachusetts has placed prominent emphasis on expanding eligibility for Medicaid to extend health care coverage to many more residents than would have been eligible before the advent of MassHealth. As unemployment rises and the economy remains sluggish, the number of people eligible for MassHealth can be expected to rise—this will increase utilization of services paid for by the program and, therefore, Medicaid expenditures, even without any provider rate increases. Moreover, because utilization of services by Medicaid enrollees appears to be concentrated in higher-cost teaching hospitals, the increase in expenditures that arises from increased

enrollment (and therefore, utilization) may be steep.

Recognizing this context is important as the state's political leaders assess their priorities and policy options for the Medicaid Program. State revenues are declining; health care costs are increasing; Medicaid enrollment, and with it, utilization, are likely to grow. As leaders face pressure for provider rate increases, they will also face pressure to spend limited state dollars on other purposes, including maintaining Medicaid eligibility and service coverage. They will need to evaluate the appropriate role of Medicaid in financing health care providers, some of which may be in poor financial condition due to business strategies that have not proven effective. Examples include the acquisition of physician practices and the investment by some nursing homes in services that are no longer highly compensated by Medicare.

They will also need to assess the value of accommodating the current trend, exhibited in some areas in the state, of greater amounts of care being provided by higher-cost providers. Finally, they will need to weigh these matters against other important public programs and goals. That challenge has become even greater in light of the need to devote resources to public safety and preparedness that has come into focus since the September 2001 attacks on the United States.

In contrast to the broad context in which state leaders must assess their priorities, health care alone was the focus of the Task Force and the working groups. Moreover, within that arena, the Task Force and working groups discussed particular issues in a serial fashion. Although this report attempts to place many of those issues into context with respect to the health care system, neither the Task Force nor the working groups have attempted to rank, by importance or any other characteristic, the interventions that are outlined and in some cases recommended. It remains for the state's policy and political leaders to determine where health care priorities fall within the state's overall obligations, and which of the health care goals and priorities are the most important.

Endnotes for I: Introduction

1. The Task Force was created jointly by then-Governor Paul Cellucci, then-Lieutenant Governor Jane Swift, Speaker Thomas Finneran and Senate President Thomas Birmingham. The only document memorializing the Task Force creation is a joint press release (see page ix).
2. A list of the working groups and their composition is on page xiii.
3. According to a recent survey by the Massachusetts Division of Health Care Finance and Policy, premiums for family coverage in the greater Boston area have risen by as much as 50% in the last four years, and the employee-paid portion of those premiums has increased by 45%. Source: DHCFP Massachusetts Employer-Sponsored Health Insurance Survey.
4. The FY01 General Appropriation Act (GAA) included a $68.6 million rate increase for nursing facilities over 2000 levels, with $35 million of this amount restricted to funding increases in wages and related employee costs for certified nurses' aides. In addition, $5 million was appropriated for a career ladder grant program in long-term care and $1 million for a certified nurses' aide training scholarship program.
5. The FY02 GAA appropriated $15 million for nonrecurring payments to financially distressed hospitals and another $15 million for nonrecurring rate enhancements for acute care hospitals.
6. There appears to have been some improvement in HMOs' financial positions which is helpful in stabilizing the system of insurance coverage.
7. Kowalczyk, Liz. "Spending on Health Care Rises 7 Percent. Hospitals, Drug Costs Contribute to Fastest Acceleration in 12 Years," *The Boston Globe*, January 8, 2002.
8. Medicaid represents 14% of patients and 10% of revenue in the hospital arena, but 72% of patients and 55% of revenue in the nursing home arena.

II: The Massachusetts Health Care System

The Cost of the System

Many members of the Finance Working Group believe that the most significant problem facing the Massachusetts health care system is that the gap between costs and revenue, sustained over a period of time, has led to a precarious situation in which a number of providers have been in prolonged financial distress, some of which are in danger of closing. If this happens, the Commonwealth could experience problems in access to care for some populations and geographic areas, and quality problems for those overwhelmed providers that remain. In addition, if lower-cost and more efficient providers close, then arguably, base costs of our system of care will be even higher.

This problem occurs in the context of a health care system that is already expensive. In addition, the increases in our health care expenditures over the last several years have been significant. Employers, consumers and public payers may reach the limit of their ability and willingness to pay more for health care before the system reaches financial stability.

Individual providers who believe they are already as efficient as they can be[9] may be unable to respond quickly enough to calls for greater efficiency in the system overall. Yet those calls are prompted by trends that are increasing the aggregate costs of the system, such as the trend of more care being provided in more costly hospital settings, particularly in areas close to major teaching hospitals. Because this increase in the proportion of services provided by higher-cost providers increases payers' overall expenditures, payers (including the state and private payers) may try to resist rate increases that would further escalate expenditures.

Closing the cost-revenue gap at the individual provider level simply by demanding more revenue is not sustainable over the long-term. Public and private action on both sides of this core problem—increasing revenue flowing into the system and decreasing overall health care costs (or at least the rate of increase in those costs)—will be required to ensure increased stability in the system.

This core problem is a result of the compounded effect of several long-standing characteristics of the health care system, recent changes in revenue streams that support providers, forces driving health care costs nationally, and trends in Massachusetts that are aggravating cost escalation and financial instability. Each of these factors is outlined more fully below.

Long-standing characteristics of the Massachusetts health care delivery system.

The Massachusetts health care delivery system has long been characterized by higher costs and lower provider financial margins than most other systems in the country.[10] Compared with national averages, Massachusetts has:

- a high cost of living, which prompts health care workers to demand higher wages;[11]
- more specialists and physicians overall per population (see Figures 32 and 33 on page 53);
- more teaching hospitals (which tend to be higher-cost) as a percentage of hospitals overall, and much higher utilization of teaching hospitals;
- much higher utilization of hospital outpatient departments and somewhat higher

utilization of EDs (see Figures 2 below and Figure 3 on page 11);

- historically lower hospital operating margins; and
- higher utilization of nursing facilities.

Recent changes in revenue streams.

Certain changes in provider payment systems have had pronounced effects in Massachusetts and have contributed to provider financial distress. Those changes include:

- the Balanced Budget Act of 1997 (BBA) which cut Medicare payments affecting hospitals, home health care providers, and nursing homes;
- cuts in Medicare payment for graduate medical education which hit particularly hard in Massachusetts in light of its high percentage of teaching hospitals; and
- hospitals contracting with HMOs for relatively low payment rates, which occured a number of years ago.

As the HMOs' market share increased to one of the highest managed care coverage rates in the country, more people were covered by lower-paying managed care plans and fewer people were covered by higher-paying indemnity plans. This shift led to a net reduction in private reimbursement relative to the cost of care provided to privately insured patients. The net reduction in private revenue, in relation to costs, has reduced the ability of health care providers to cross-subsidize services provided to Medicaid patients, and has focused debate on the appropriate level of Medicaid payments, which have traditionally been below reported costs.

These changes have contributed both directly and indirectly to financial stress among different types of providers. For example, as hospitals have become more

Hospital Outpatient Visits per 1,000 Population: Massachusetts versus the United States

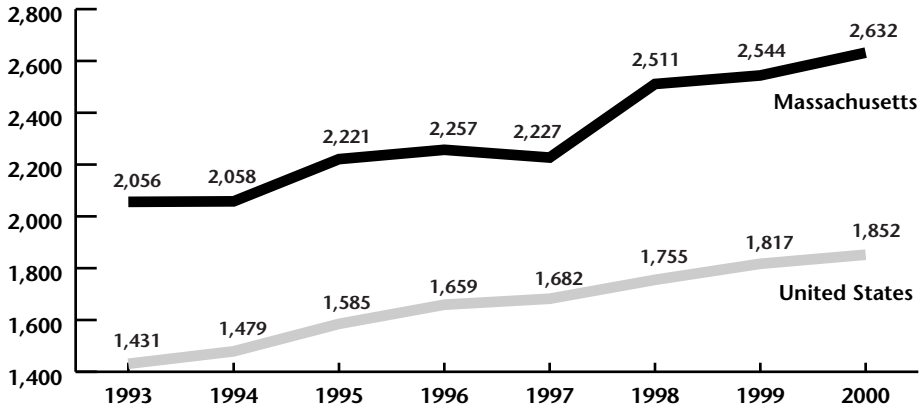

Figure 2

Utilization of outpatient services increased throughout the 1990s. Massachusetts outpatient hospital utilization has been consistently higher than the national average and is increasing at a faster rate.

Note: AHA population data was adjusted annually in the 1999-2002 reports to reflect variation between projections and estimations. AHA statistics include both acute and non-acute hospitals. Total outpatient visits include ED visits.

Source: AHA Hospital Statistics, 1999 edition (1993-1997 data) and 2002 edition (1998-2000 data)

Acute Hospital Emergency Department Visits per 1,000 Population: Massachusetts versus the United States

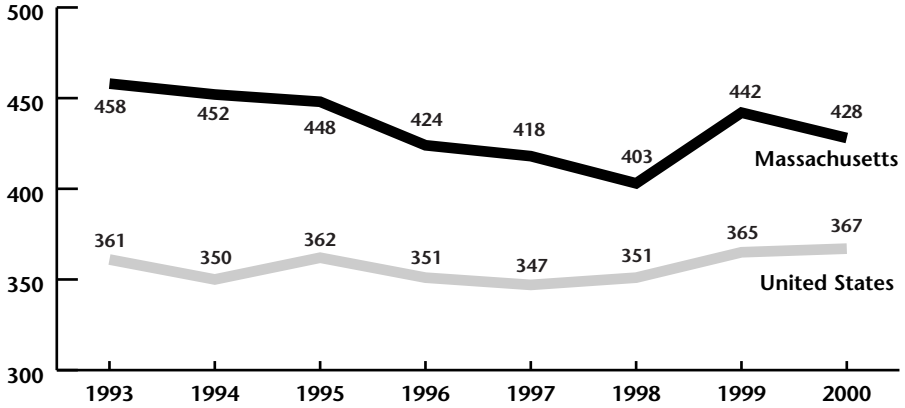

Figure 3

Utilization of ED services slightly declined during the mid-1990s, but has been increasing since 1998. Massachusetts utilization continues to be higher than the national average.

Note: AHA population data was adjusted annually in the 1999-2002 reports to reflect variation between projections and estimations.

Source: AHA Hospital Statistics, 1999 edition (1993-1997 data) and 2002 edition (1998-2000 data)

distressed, they have been less able to support other providers such as community health centers. Thus, even though the BBA did not affect community health centers as directly as hospitals, it did contribute indirectly to their financial distress.

Forces driving cost increases and health care inflation nationally.

Forces driving health care cost inflation include:

- Utilization of new and expensive prescription drugs is skyrocketing (see Figures 37 and 38 on pages 57 and 58).

- Research and technology continually add costs to care.[12]

- A nursing shortage caused labor costs to rise faster than payments for services. Still, it is difficult to find nurses to take positions on the front lines of care[13] (see Figures 35 and 36 on page 56). Health care labor costs increased much faster in 2001 than they had in earlier years (see Figure 4 on page 12).

- Demand for hospital inpatient and ED services which have been increasing rapidly in the last several years after a period of lower demand for those services and consolidation in the hospital system (see Figures 5 and 6 on page 13).

- Outpatient hospital services continue to expand at a rapid rate.

Trends in Massachusetts exacerbating cost increases and financial stress.

Trends in Massachusetts that are exacerbating overall cost increases and financial stress include:

- Increased use of teaching hospitals and declining use of community hospitals in

Hospital Labor Cost Inflation, National Yearly Average, Q3

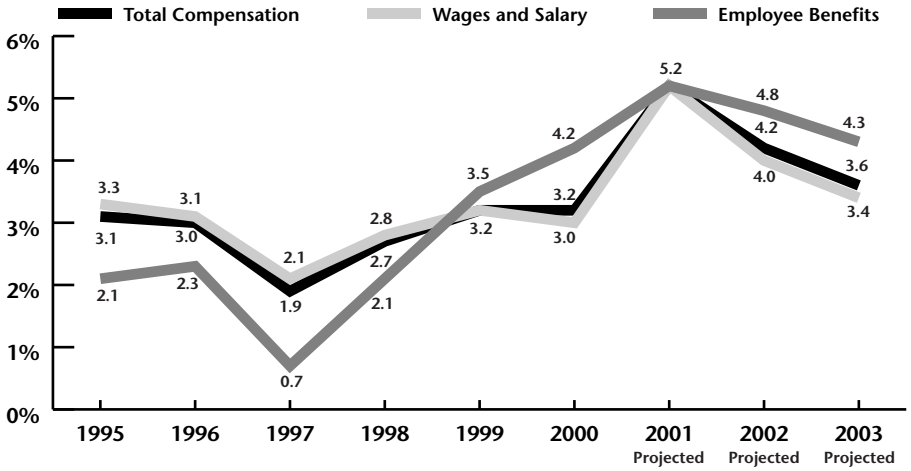

Figure 4

Although labor cost inflation is projected to decrease beyond Q3 2001, the average yearly inflation in total compensation increased from 1.9% in 1997 to 5.2% in 2001. Hospitals increasingly offered greater benefits per year to supplement wages and salaries, from 0.7% inflation in 1997 to 5.2% in 2001.

Source: Health Care Cost Review: Third-Quarter 2001, DRI

areas where both teaching hospitals and community hospitals are geographically accessible (see Figures 12, 13 and 14 on pages 29-31). The loss of revenue accompanying the shifting patient volume is crippling some community hospitals.

- Utilization of hospital outpatient services is much higher in Massachusetts than in the nation on average, while payment rates for those services have traditionally been less than cost as a means of encouraging use of lower-cost settings.[14]

- Utilization of ERs is increasing rapidly, especially given the context of already high use and a decrease in the number of ERs available due to the number of hospital closures in recent years.

- Health insurance premium increases in Massachusetts reflect the combined effect of improving insurers' bottom lines and financial reserves, increased utilization, and higher provider payments.

- Massachusetts premiums, historically higher than the national average, have increased more slowly than premiums nationwide, so that the amount by which Massachusetts premiums exceed the national average has decreased. There does not appear to be a similar decrease in the amount by which the cost of the covered care exceeds the national average (see Figures 7 and 8 on page 14).

Options

As outlined above, many factors contribute to the high cost of our system and its rapid cost increases. Those factors related to long-standing characteristics of the health care system in Massachusetts and to Medicare payment policy changes will be difficult or impossible to address with the types of actions the state has traditionally used

Acute Hospital Inpatient Days per 1,000 Population: Massachusetts versus the United States

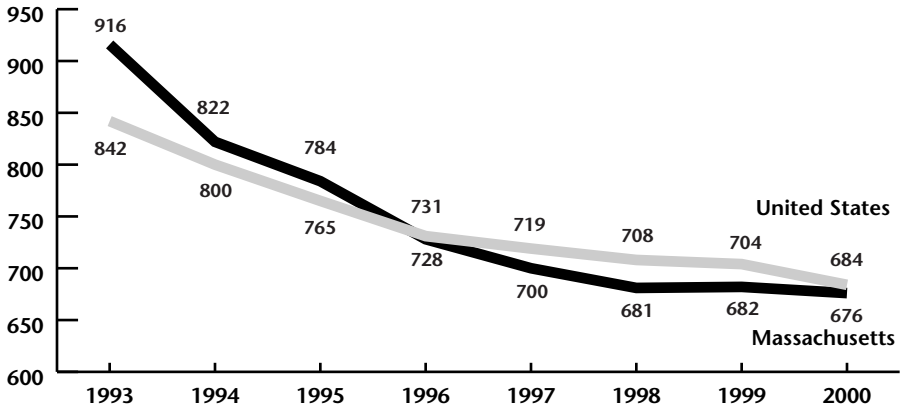

Figure 5

Utilization of inpatient services has declined throughout the 1990s. From 1993-98 Massachusetts inpatient utilization declined faster than the national rate. Since 1996, Massachusetts inpatient utilization has been slightly lower than the national average.

Note: AHA population data was adjusted annually in the 1999-2002 reports to reflect variation between projections and estimations. AHA statistics include both acute and non-acute hospitals.

Source: AHA Hospital Statistics, 1999 edition (1993-1997 data) and 2002 edition (1998-2000 data)

Massachusetts Hospital Consolidations by Year and Type

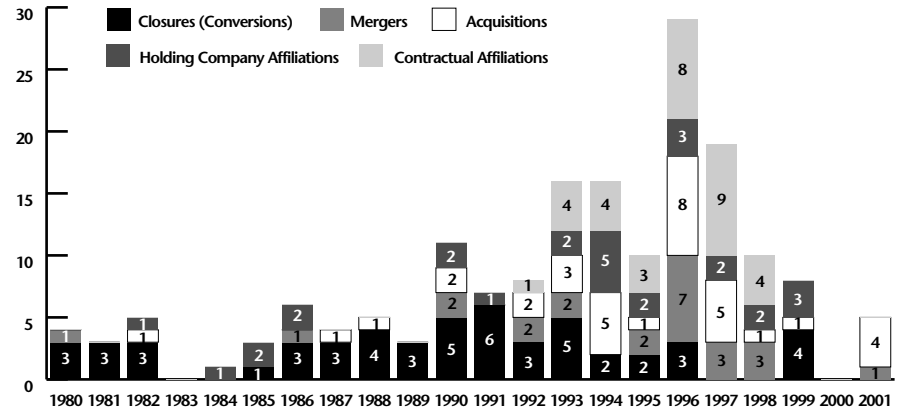

Figure 6

The organization of Massachusetts hospitals experienced a large number of consolidations during the past two decades. This reorganization was marked by 39 closures in ten years (1986-1996), as well as 20 mergers and 33 contractual affiliations since 1992. The consolidation rate has slowed in the last few years.

Note: Data for 2000-2001 are from the Massachusetts Division of Health Care Finance and Policy.

Source: Massachusetts Hospital Closures/Conversions, Mergers, Acquisition: 1980-Present, MHA, 1999

HMO Monthly Premiums: Massachusetts versus the United States (1990 and 1998)

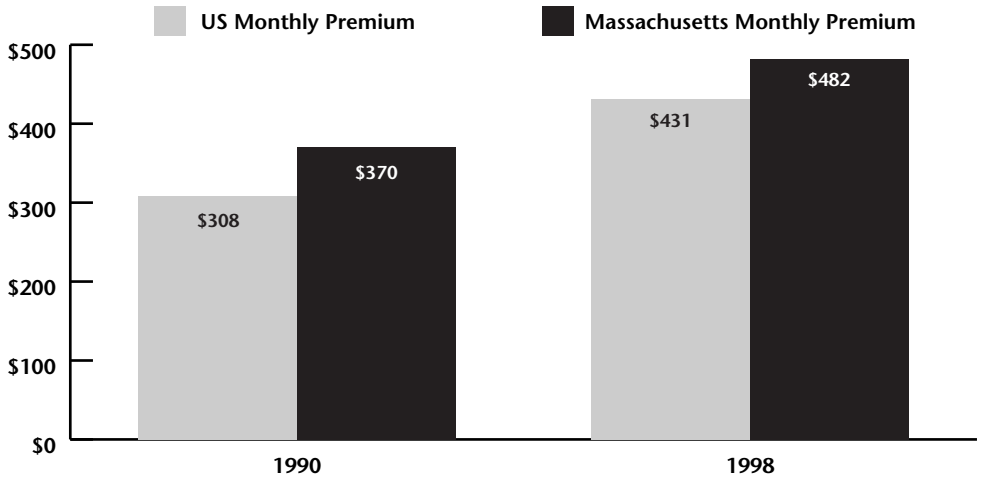

Figure 7

Massachusetts monthly premiums have consistently exceeded US averages, however, from 1990-1998 Massachusetts premiums increased more slowly than the nation as a whole.

Source: US Department of Health and Human Services, *Health, United States, 1999*; Massachusetts Division of Health Care Finance and Policy, *Massachusetts Health Care Trends: 1990-1999*

Health Care Expenditures per Capita: Massachusetts versus the United States (1990 and 1998)

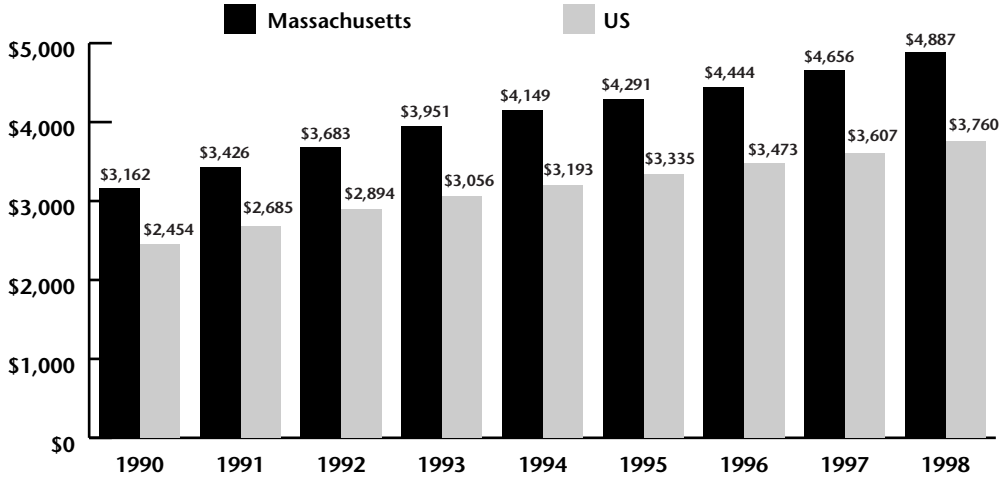

Figure 8

Per capita health care spending in Massachusetts increased slightly faster than the national average. Massachusetts per capita spending has consistently been significantly higher than the national average.

Note: Figures are not adjusted for inflation.

Source: HCFA, Office of the Actuary, National Health Statistics Group, "Massachusetts Health Expenditures, 1989-1998," July 17, 2000; Massachusetts Division of Health Care Finance and Policy, *Massachusetts Health Care Trends: 1990-1999*

or contemplated. Also, it is unclear that the residents of the Commonwealth desire a radically different health care system.

The factors contributing most significantly to system cost increases are the trends of increasing use of high-cost prescription drugs and new diagnostic and treatment technology, and increasing use of teaching hospitals, hospital outpatient departments, and EDs.

At a general level, options for responding to those trends are to:

1. Accept the situation and pay more for care than would be necessary if lower-cost settings or treatments were used;

2. Impose restrictions to forcibly redistribute care to lower-cost settings whenever appropriate;

3. Engage in more aggressive regulation of provider activity, such as industry controls on prices and costs;

4. Pursue quality-based incentives to encourage effective and efficient care (including evaluation of appropriate use of costly new technology and prescription drugs), and consumer education to encourage prudent choices;

5. Create economic incentives to encourage use of lower-cost providers whenever appropriate and support the development of lower-cost community-based care; and

6. Increase monitoring of the system through data collection and analysis and studies, as appropriate.

Each of these is discussed in detail below.

1. *Paying More.* It is likely that we will pay more than we do now to support our higher-cost health care system. But simply accepting whatever higher costs are generated by the increasing use of higher-cost settings and expensive treatments may not be desirable for the community in the long run. As outlined more fully in the discussion of hospital issues below, these trends could lead to two kinds of higher costs: 1) the shift of patient volume to higher-cost settings, and 2) the resulting higher treatment costs for patients treated in those higher-cost settings, and distressed provider support costs if the lower-cost providers that are losing volume are deemed necessary for the preservation of access to certain important services.

   Premiums are already higher in Massachusetts than in the nation, on average (see Figure 7 on page 14). Even though the gap between Massachusetts and the nation has narrowed in recent years (see Figure 8 on page 14), Massachusetts employers are still faced with higher costs than their counterparts in other states (see Figure 9 on page 16). The higher employee health care costs are in line with the higher cost of living in Massachusetts, however, unchecked continued increases could make Massachusetts an unattractive business venue.

   Even if we adjust to higher system costs, there could be severe consequences for those who lose insurance coverage because it becomes unaffordable for them or their employers. It could also entail serious consequences for state government, which could face increased Medicaid enrollment and increased uncompensated care costs. The resulting budget pressures would inevitably lead to pressures to cut provider payments and to reduce Medicaid benefits or enrollment.

2. *Forcible Redistribution of Care.* On the other hand, forcibly redistributing care is unlikely to be successful. Managed care tried this approach through coverage

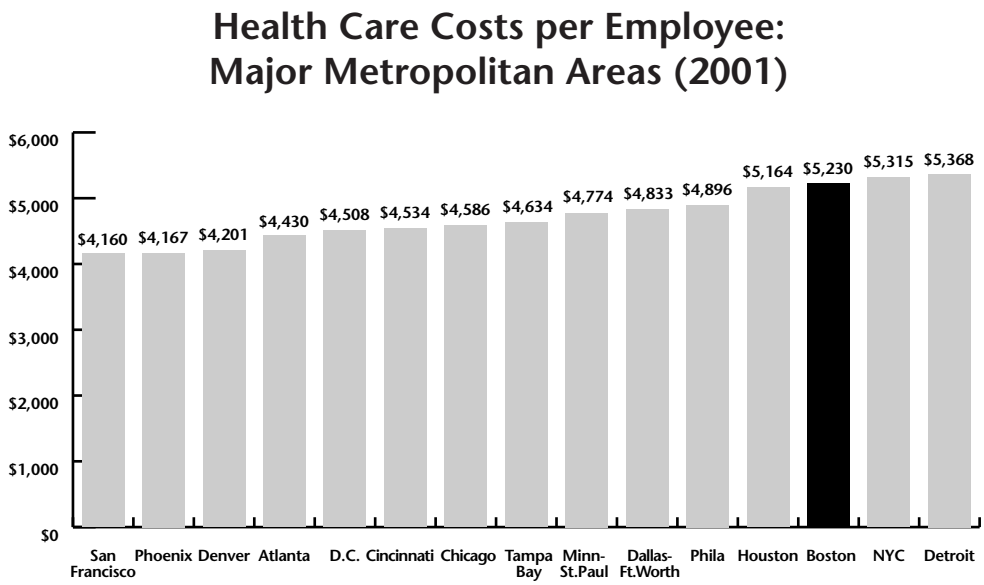

Figure 9

Boston area employers are faced with higher employee health care costs than employers in most other major metropolitan areas.

Source: Hewitt Associates, *Hewitt Health Value Initiative*, 2001

restrictions, and the response of the state legislature was to curtail this type of cost-control device. It is unlikely that the state would impose similar restrictions through its regulatory authority. Some members of the Finance Working Group would support redistribution of Medicaid enrollees' care to lower-cost providers through program rules (e.g., designating a hospital as the primary hospital provider for Medicaid enrollees in its defined service area, subject to the hospital's ability to provide medically appropriate care).

3. *Government Regulation and Planning.* Government intervention could also take the form of more aggressive health planning and regulation of provider activity. The state could engage in more cost-focused regulation of permissible provider service mixes and provider relationships, or rate regulation. These kinds of strategies have been tried in the past with mixed results. While some Finance Working Group members would encourage greater government involvement, others are skeptical about the potential of this strategy to improve the situation.

Short of regulation, however, it makes sense for a small number of government leaders to engage in planning for actions the government can or might want to take in the event of widespread limits on access to care due to reduced insurance coverage. In addition, the state can increase coordination among state agencies in identifying needed and "at risk" providers, and in determining whether state financial intervention might be indicated.

A related option is receivership legislation that would allow the state to take over a troubled hospital or other provider where deemed necessary, although the interaction between receivership and bankruptcy regimes would have to be

explored and clarified. That strategy could prevent severe crises, but also presents difficult judgments about which providers are truly needed and which conditions require such drastic intervention. Many people are skeptical about the state's ability to make these judgments. Others believe that a comprehensive assessment of needed services and providers would help inform the actions of decision-makers who now face crises with individual providers only after they file notices to close services or entire operations.[15]

4. *Quality-based Initiatives*. Employers are exploring several quality-focused techniques with the goal of improving outcomes and reducing overall costs. These include improving information available about quality and cost to encourage consumers to make prudent choices of treatments and providers, and developing incentives for providers to reduce medical errors and overall treatment costs through effective disease management and consistent use of evidence-based medical protocols.

   The state should explore whether it can assist lower-cost providers in improving quality of care and in educating consumers about the quality they offer through grants or loans, technical assistance, or both. In addition, the state could explore ways to improve the collection and reporting of information about provider quality and cost, with the goal of supporting prudent consumer choices.

5. *Economic Incentives*. Engaging consumers and providers through incentives may be successful in constraining, to a degree, the rate of cost increases. Employers are pursuing several kinds of incentives, outlined more fully in the discussion of employers below. Economic incentives can be blunt instruments, as is the case with new health plan designs that impose higher copayments for services delivered at teaching hospitals, even if the teaching hospital setting is clinically indicated. They can also be effective in controlling costs without impairing quality, as with the tiered copayment systems employed in many drug benefit plans.

   Economic incentives are worth exploring as a means of influencing consumer choice among clinically appropriate providers. The state has more limited ability to employ consumer incentives with Medicaid enrollees, but should explore whether it is possible to use some financial incentives to encourage choice of lower-cost providers where clinically appropriate, without imposing undue burdens on enrollees.

   The Medicaid program already employs certain provider incentives, such as paying lower rates for hospital outpatient care that could be delivered in lower-cost settings. The effectiveness of those incentives has been limited, in part by a lack of sufficient low-cost providers. Nevertheless, the Finance Working Group believes that provider incentives should be part of any Medicaid rate reform plans. An appropriate complement to this strategy would be investment in the development of capacity among lower-cost community-based providers such as physician offices and community health centers.

6. *Increased Monitoring*. Many working group reports and Task Force discussions pointed to the need for more data about the health care system and more state monitoring of trends and conditions. The Finance Working Group recommended increasing the frequency of provider financial reporting and state analysis of those reports, and that policy is being pursued under recently enacted authority, as referenced above. Areas of particular stress and concern, such as ED utilization, may require additional focused data collection and

study efforts to develop effective interventions.

In addition to recently implemented data collection concerning ED utilization, the state should develop the capacity to design and implement targeted data collection and studies in a short period of time to inform policy and intervention strategies.

Government planning, quality initiatives and economic incentives should be undertaken in collaboration with payers and providers. Even if each individual stakeholder has a strong interest in protecting patient volume and market share, all stakeholders have a stronger interest in controlling the rate of cost increases so as to preserve the system itself. Appropriate steering of care to lower-cost, clinically appropriate providers may be necessary to ensure that the system remains functional and affordable.

Access

The Access Working Group presented its report on access to health insurance to the Task Force in November 2000. Plans for a second report on access to care, particularly as affected by the financial condition of hospitals and community providers in various geographic regions, unfortunately did not come to fruition. Instead, due to a combination of factors including limitations of time and resources, unavailability of some Access Working Group members, and considerable overlap between the discussions in the Access and Finance Working Groups, members of the two groups were merged in late 2000 and the resulting larger working group focused on finance issues. The report on access to care, independent of insurance status, but as influenced by financial conditions, is a project the state should pursue as part of increased monitoring, agency coordination and planning recommended throughout this report.

At the time of its presentation to the Task Force, the Access Working Group was able to cite dramatic reductions in the number of uninsured residents in the Commonwealth between 1998 and 2000. Those reductions were due primarily to the expansion of the MassHealth program, and to the strong economy and low unemployment rates prevalent at the time. Now, of course, the situation is dramatically different. Unemployment is rising and Massachusetts can expect increases in the percentage of residents without insurance and increases in MassHealth enrollment.[16]

The Access Working Group noted that lack of insurance is not a total barrier to receiving care in Massachusetts, as there are many programs here that facilitate access to care for people who do not have insurance or the means to pay for their care. An outline of the programs the Commonwealth sponsors that pay for care is included in the Access Working Group report. Still, increasing access to affordable health insurance is an important goal because insurance coverage facilitates access to care. A person's lack of health insurance affects the likelihood that he or she will seek health care services. Lack of health insurance is also associated with reduced health status.

The Access Working Group recommended an incremental approach to expanding access to insurance and described a number of strategies that would further that approach.[17] Among the strategies it recommended for exploration, with financial analysis and additional information, were to:

1. Expand MassHealth, by income level or category.

2. Combine and streamline state programs, wherever possible, to reduce administrative complexity and confusion.

3. Consider alternative insurance product design, such as high-deductible policies

with subsidies to help low-income enrollees meet those deductibles.

4. Provide tax credits or subsidies to employers or employees, or both, for the purchase of commercial insurance.

5. Consider mandates on employers to offer insurance or on individuals to obtain and maintain insurance.

6. Explore insurance regulation reform, such as revised rate banding requirements or changes to permissible product design, to facilitate the creation of more affordable insurance products.

7. Educate employers about the tax advantages of paying for health care through medical savings accounts and flexible spending accounts.

8. Include "Indirect mandates" by the Commonwealth requiring all its contractors to provide health insurance to their employees (supported by appropriate levels of payment for services by the state).

9. Assess the impact the mandate would be likely to have on insurance premiums before enacting mandated benefits.

The Access Working Group suggested pursuing several strategies at the same time, because no single approach would succeed in making adequate and affordable insurance available to all residents. In light of substantially changed circumstances, it should be acknowledged that MassHealth expansion is unlikely. State revenues have fallen, Medicaid spending is increasing commensurate with health care cost increases, and MassHealth enrollment is likely to increase without eligibility expansions. However, regulatory changes by the state that could permit more affordable insurance products are still worth exploring.

Some Task Force members were skeptical that increasing consumer financial responsibility for care would be wise, even if a plan that incorporated higher copayments or deductibles could be purchased for a lower premium than would be charged for more comprehensive coverage. Others supported the idea of increasing consumer financial responsibility as an important strategy in encouraging cost-conscious choice of provider. This strategy could, in the long-term, be an important means of controlling aggregate system cost increases.

At the time of the Access Working Group's report, the Commonwealth had recently been awarded a state planning grant by the federal Health Resources and Services Administration for the purpose of developing a plan to make affordable comprehensive health insurance accessible for all Massachusetts residents. The Final Report prepared with that grant is expected in the fall of 2002.

Quality

The Quality Working Group

The Quality Working Group presented two reports to the Task Force and led thoughtful discussions about its findings with respect to quality of care in the Commonwealth and its suggestions for improving quality of care in the system.

The Quality Working Group recommended that the Commonwealth adopt Professor Jon Chilingarian's multi-dimensional definition of quality, which is patient-centered and identifies five underlying dimensions: patient satisfaction, information and emotional support, amenities and convenience, decision-making efficiency, and outcomes.[18] The Quality Working Group also noted that the Institute of Medicine's definition of quality appears to be the most widely accepted: "the degree to which health services for individuals and populations increase the likelihood of desired health out-

comes and are consistent with current professional knowledge."

The following points are findings of the Quality Working Group:

- Though quality means different things to different stakeholders, the various dimensions of quality are definable and can be measured to address various stakeholders' interests.

- There is no automatic direct correlation between health care spending and quality, and the efficient allocation of available resources is more likely to have a positive impact on quality than increased spending alone.

- Medical errors and less than best-practice quality contribute to the financial problems facing the state's health care system, in addition to increasing unnecessary suffering.

- The usefulness of currently available quality information is questionable because provider-specific differences are buried in health plan averages and little information is collected from the outpatient setting, where increasingly more care is provided.

- In general, consumers do not use objective quality information when making decisions about care and providers, relying instead on the assessments of family and friends. There is a need for better consumer education on quality, despite the lack of flexibility in provider choice some consumers have because of restrictions in their health benefit plans.

- Financial and staffing difficulties have prompted particular concern about quality of care in the nursing home industry, where monitoring of quality needs to be vigilant.

- Providing the highest quality of care to each patient and reducing the possibility of error is not always the primary focus of providers today. This is true for many reasons, including the burden of administrative requirements and financial incentives that work against a focus on patient safety.

- Despite exemplary voluntary quality improvement and medical error reduction efforts underway in the Commonwealth (such as the Mass Health Quality Partnership and the Coalition for the Prevention of Medical Errors), culture, finance and practice inhibit the rate of adoption of evidence-based care guidelines, improvements in patient-oriented information technologies and a focus on ambulatory care settings where most care is now provided for people with chronic conditions—especially mental illness.

The Quality Working Group offered several suggestions for state policy development and interventions that would improve quality of care and patient safety in the Commonwealth:

Align state policies and practices to foster quality improvement and error reduction.
The state should review regulations, contracts and payment policies to ensure that they focus on patient-centered quality and quality improvement efforts. For example, the Commonwealth should consider providing incentive payments to providers who demonstrate improvements in patient-centered quality, and over time, should consider terminating relationships with providers who do not achieve appropriate levels of quality and error reduction.

Expand and improve data collection and reporting on quality and medical errors, especially in non-acute settings and at the provider-specific level.

The state should work with health plans, providers and groups working on medical error reduction, such as the Mass Health Quality Partnership and the Coalition for the Prevention of Medical Errors, to collect and disseminate provider-level profiles of quality of care and errors. These efforts should include the collection and reporting of information from outpatient and office settings. Reporting requirements should focus on the most important areas for improvement, so as to minimize the burden of additional reporting requirements.

Develop and implement evidence-based practice guidelines.
Providers, payers and regulators should work together to develop evidence-based practice guidelines, and to identify and work to eliminate barriers and resistance to the implementation of those guidelines. As part of this effort, the Commonwealth should develop a method of tracking and reporting on the most commonly occurring medical conditions, and should focus the development and dissemination of evidence-based best practices on these conditions.

Financial incentives should encourage patient-centered quality improvement.
The Commonwealth should target financial assistance to health care providers for projects that yield measurable improvements in patient-centered quality (e.g., computerized physician order entry systems). Payment systems in general should include incentives such as bonus payments for providers that demonstrate measurable achievements in patient safety.

Consumer education.
The Commonwealth should coordinate and expand its efforts in consumer education about quality of care. A comprehensive consumer education initiative should incorporate the current periodic publications by the Group Insurance Commission and the Office of Consumer Affairs and Business Regulation.

Guest Presentation: Professor Lucian Leape

In June 2001, Professor Lucian Leape of the Harvard School of Public Health presented to the Task Force some of the findings of the Institute of Medicine (IOM) with respect to medical errors, and offered certain suggestions. The IOM concluded that the cause of medical errors is bad systems-rather than bad people, that we need to redesign our systems, and make patient safety a national priority.

Professor Leape advised that the focus on systems is important because individuals will, invariably, make mistakes. Errors can be prevented by designing tasks and processes to minimize dependency on weak cognitive functions such as short-term memory and attention. Lessons from "human factors research" offer the following principles for error reduction: avoid reliance on memory, simplify, standardize, use constraints and forcing functions, use protocols and checklists, and avoid fatigue. Current medical culture generally runs counter to many of these principles.

In addition, focusing on systems rather than individuals reduces the "blaming culture," which is singularly ineffective at preventing errors and injuries. That culture also can lead to dishonesty and cover-up, and it diverts attention away from systems problems and improvements.

Recommendations:

- Health care professionals should follow best practices, identify unsafe systems, and help change those systems; be honest with patients; and take responsibility for those individuals who are problematic.

- Hospitals and health care organization CEOs should take responsibility for patient safety, because safety is primarily a function of systems.

- The culture in the health care system should change—best practices should be implemented, and systems should be changed, including general systems such as staffing plans that impose burdensome hours and workloads, and specific systems such as computerized physician order entry systems.

- Safety should be part of any health care organization's strategic plan; punishment of individuals for errors should be avoided; safe medication practices should be implemented; and there should be a general hunt for hazards.

- Regulatory policy should focus on safe practices and move away from focusing on individuals, blaming and punishment; it should offer individuals protection against disclosure (provided that "problem" providers are addressed); it should require safety programs in health care organizations; and it should set specific standards (e.g., maximum hours for house staff, staffing ratios, etc.).

The Leapfrog Initiative

Although there was not a Task Force presentation focused specifically on the Leapfrog initiative, the Finance Working Group discussed the initiative several times and it is becoming an important force. The Leapfrog Group is an initiative sponsored by the Business Roundtable to increase the quality and therefore the cost-effectiveness of health care. Its members identify hospitals that meet certain specific quality standards—hospitals that (a) employ specially-trained intensivists in their intensive care units, (b) perform more than a threshold number of certain complex procedures each year, and (c) have implemented computerized prescription order entry systems. Each of these criteria is clearly measurable and is associated with better outcomes. The Leapfrog goal is to improve quality of care and to reduce costs associated with errors or sub-optimal care by steering patients toward providers who meet the criteria associated with higher quality. The Commonwealth's Group Insurance Commission has adopted the Leapfrog principles.

The Finance Working Group supports the effort to encourage adoption of systems that improve quality of care, but is concerned that the Leapfrog criteria are more likely to be met by more expensive and more financially robust teaching hospitals than by community hospitals. The effect of focusing on these particular measures could be to drive even more care to teaching hospitals, even in cases where quality may not be better than at community hospitals. The Finance Group suggests that the Leapfrog measures be supplemented with outcome information that will also show high-quality community hospitals as desirable providers for an array of inpatient services.

There is some tension between recommendations that stress the publication of provider-level quality and medical error information and those that stress confidentiality for individual providers and a focus on systems improvement. The recently created Betsy Lehman Center for Patient Safety and Medical Error Reduction will provide the Commonwealth with a forum for resolving those tensions and pursuing quality improvement initiatives in health care.

Administrative Simplification

The Administrative Simplification Working Group was created to develop strategies and suggestions for reducing administrative cost and complexity in the health care system. It did not analyze costs to determine precisely what percentage of health care expenditures relate to unnecessary administrative costs. Instead, it started from the premise that regardless of the percentage of health care dollars associated with adminis-

trative complexity, participants in the health care system should take steps to reduce it.

The Administrative Simplification Working Group members agreed that "administrative simplification," for the working group's purposes, means reducing the degree of complexity and improving the degree of accuracy in the exchange of information among providers, insurers and employers. The group endorsed encouraging electronic communications in exchangeable formats among providers, payers and employers; and expanded broadly available Internet-based communications systems. The group discouraged imposition of state-level standards for electronic communications and for compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Each working group member was constrained by the legacy systems of his or her organization, the need to comply with HIPAA in the most cost-effective way based on those systems, and the need to devote scarce resources to HIPAA compliance in the first instance due to looming federal deadlines and penalties. They did agree in principle that such performance standards would be helpful and would allow them to focus on results rather than adoption of or investment in particular technologies.

The Administrative Simplification Working Group focused on suggesting ways in which the state could help providers, payers and employers comply with federal standards imposed by HIPAA, and ways to help providers, payers, employers and public agencies use HIPAA compliance efforts to achieve broader administrative simplification gains.

Among the Administrative Simplification Working Group's observations and recommendations were the following:

- The Commonwealth should act as convenor and facilitator rather than regulator with respect to health care administrative simplification. It should also set a good example by simplifying its own processes and pursuing efficient and timely HIPAA compliance.

- HIPAA compliance efforts should be tied to broader administrative simplification efforts.

- The Commonwealth should rely on and work in collaboration with the Massachusetts Health Data Consortium in coordinating private sector HIPAA compliance and administrative simplification efforts.

- The Commonwealth should coordinate its HIPAA compliance efforts in a statewide strategy that serves as a framework for broader administrative simplification in the future.

- The Commonwealth should request health care system participants to submit information periodically showing their progress in support of HIPAA compliance and administrative simplification; a suggested mechanism for this purpose is creation of a high-level review panel that would meet periodically to hear publicly from payers, providers and other system participants about their efforts, achievements, and challenges.

- Industry performance standards for administrative matters should be developed, and payers, providers and employers should report periodically on the extent to which they meet those standards. Examples of possible standards include instant adjudication of clean claims upon receipt by payers, availability of written explanations of benefits at the point of service, electronic funds transfer options for payment of claims and copayment, and availability of statements of account through the Internet. The group did not adopt specific standards, rec-

ommending instead that the Massachusetts Health Data Consortium lead the effort, with its collaborative operations and information officers' forums, to agree on performance standards that can best leverage HIPAA compliance efforts already underway.

- The Commonwealth should support, directly or by facilitating private funding, experimentation and creativity in the development of administrative simplification approaches through demonstration projects (to develop and test new, low-cost technologies) and centers of excellence (to focus on sustained research and development of technologic solutions that can be used by public and private payers, and providers, to achieve administrative simplification advances).

- The Commonwealth should focus on developing technology that will help smaller providers and should encourage use of existing technology, including the Internet, among smaller providers.

An additional aspect of administrative simplification highlighted by some of the Task Force members is the observation that the state, through its various agencies and regulations, imposes unnecessary administrative complexity and paperwork burdens. The recommendation, obviously, is that the Commonwealth evaluate, coordinate and simplify the administrative burdens it imposes on health care sector participants.

Patient Flow Through the System: Emergency Department Overcrowding and Ambulance Diversion

In addition to exhibiting less than cost-efficient use of providers and high costs overall, our health care system appears to be functioning in ways that impede patient flow, as demonstrated by the widely-publicized phenomenon of ED overcrowding and ambulance diversion. The problem raises questions about whether our system has the appropriate resources in the appropriate settings, and about whether resources are being utilized optimally.

The Finance Working Group met several times with Dr. Howard Koh, Commissioner of the Department of Public Health, and several members of Commissioner Koh's Task Force on Ambulance Diversions to discuss the issues. In October, 2001, Commissioner Koh and Dr. Michael McManus, who has drafted an *Issue Brief* on the topic for the Massachusetts Health Policy Forum,[19] presented to the full Task Force on the issue. The problem is complex and its causes and possible solutions are not clear. Drs. Koh and McManus observed:

- Demand for ED services is increasing.

- Admissions per hospital and per bed are increasing.

- The number of hospital beds in Massachusetts is lower than it has been for many years.

- Ambulance diversion correlates with total hospital occupancy more than with ED volume.

- Hospitals are forced by the pursuit of efficiency toward very high census and controllable patient flow.

- The ED is mandated to treat all arrivals and therefore cannot control its patient inflow. As a result, overall hospital capacity limits show their effects first in the ED (i.e., when the hospital is "full" overall, the ED becomes overloaded because there is no "back door" through which to admit patients requiring inpatient services).

Dr. Koh and Dr. McManus concluded that, in light of the fact that fewer EDs attached to fewer hospitals are facing increased demand for ED services, further reduction in hospital and ED capacity would carry the risk that access to ED services would be impaired. Dr. McManus advised that matching variable demand to falling capacity is the new health care challenge, and it will require innovative solutions.

Commissioner Koh's Task Force, in collaboration with the Massachusetts Hospital Association, has already taken helpful steps such as developing "best practices" to help alleviate the problem. The Finance Working Group has supported Commissioner Koh's recommendation that the state sponsor further study of the issue to determine causes and support pilot programs to implement various additional strategies to determine effective ways to ease the problem.

Additional recommendations offered by Dr. McManus and Dr. Koh include the following:

- Determine the true nature of the changing demand for emergency services and encourage access to medically suitable alternatives.
- Develop and support operations management strategies for improving patient flow and relieving ED gridlock.
- Devise a method for ensuring, monitoring and adjusting overall hospital capacity.
- Address workforce shortages.

Endnotes for II: The Massachusetts Health Care System

9. The cost and efficiency problems of the system as a whole are different from those that pertain to particular providers. For example, several studies have shown that Massachusetts teaching hospitals, compared with similar teaching hospitals in other parts of the country, are not more costly or less efficient (after accounting for regional variation in input costs). The same has been shown with respect to community hospitals. See, e.g., The Lewin Group, *An Analysis of Massachusetts Hospitals' Efficiency and Costs*, prepared for the Massachusetts Hospital Association, April, 2000.
10. Research and education costs contribute to total aggregate costs in Massachusetts; these costs are generally paid for by sources other than patient care payments. When these costs are removed, however, Massachusetts health care delivery system costs remain higher than those in most other systems in the country.
11. The cost of living in the Boston metropolitan area was 33% higher than the national average of all metropolitan areas in 2000; spending on health care was 31% higher. Source: ACCRA, "ACCRA Cost of Living Index," Fourth Quarter 2000, in the US Census Bureau, *Statistical Abstract of the United States: 2001*.
12. Medicare explicitly adjusts for research and technology. Source: MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2001.
13. Vacancy rates for many technician categories are also high according to the Massachusetts Hospital Association.
14. As discussed more fully in "Sector Financial Conditions and Related Challenges," lower payments for hospital outpatient care are based in part on the theory that much of that care could be provided at lower cost in a physician office or community health center. Unfortunately, there may be areas of Massachusetts where those lower-cost settings are not readily available.
15. Chapter 141 of the Acts of 2000 requires the Department of Public Health to hold a public hearing when a hospital intends to close an essential health service or terminate operations. Although the law gives DPH no authority to prevent such closures, the hearing process has provoked discussions among policy and political leaders about intervention in each case.
16. Source: Massachusetts Division of Health Care Finance and Policy, "Premium Increases Affect Health Insurance Coverage," *Analysis In Brief*, November 2001.
17. More fundamental system reform is being considered by a separate group, the Advisory Committee on Consolidated Health Care Financing and Streamlined Health Care Delivery, created pursuant to Section 32 of Chapter 141 of the Acts of 2000.

18. The Quality Group cites the author of this definition and approach: Jon Chilingerian, Chapter 8 "Evaluating Quality Outcomes Against Best Practice: A New Frontier," *The Quality Imperative—Measurement and Management of Quality in Healthcare*, Imperial College Press, 1999.

19. Source: Massachusetts Health Policy Forum, "Emergency Department Overcrowding in Massachusetts: Making Room in Our Hospitals," *Issue Brief*, June 2001.

III: Sector Financial Conditions and Related Challenges

Hospitals

At its first meeting in June 2000, the Task Force discussed the Finance Working Group's report that the financial condition of Massachusetts' hospitals, whose operating margins had been lower than national averages for many years, had deteriorated to among the worst in the country (see Figure 10 below). At that time, the Finance Work-

Ratio of Hospital Payment-to-Cost by Payer and State (1999)

	Medicare	Medicaid	Private Payer		Medicare	Medicaid	Private Payer
US	1.02	0.97	1.12	Missouri	0.95	0.86	1.11
Alabama	1.10	0.96	1.11	Montana	0.88	0.85	1.33
Alaska	0.81	0.83	1.43	Nebraska	0.86	0.97	1.30
Arizona	1.09	0.79	1.08	Nevada	1.00	1.01	1.20
Arkansas	1.08	0.86	1.34	New Hampshire	0.92	0.74	1.23
California	1.07	0.93	1.13	New Jersey	0.93	0.90	1.14
Colorado	1.05	0.95	1.13	New Mexico	1.09	1.11	1.14
Connecticut	0.98	0.70	1.07	New York	1.04	1.05	0.97
Delaware	0.91	0.88	1.21	North Carolina	1.01	0.93	1.25
District of Columbia	1.03	1.09	1.14	North Dakota	0.88	0.96	1.28
Florida	1.04	0.83	1.22	Ohio	0.95	0.94	1.13
Georgia	1.04	0.91	1.33	Oklahoma	1.03	0.70	1.22
Hawaii	0.78	0.79	1.15	Oregon	0.98	0.93	1.10
Idaho	0.96	0.91	1.31	Pennsylvania	1.02	0.77	1.01
Illinois	0.91	0.75	1.20	Rhode Island	1.11	1.05	0.92
Indiana	0.91	0.98	1.29	South Carolina	0.97	0.91	1.43
Iowa	0.83	0.90	1.29	South Dakota	0.80	0.91	1.37
Kansas	0.92	0.65	1.30	Tennessee	1.11	0.74	1.18
Kentucky	1.00	0.85	1.26	Texas	1.01	1.06	1.22
Louisiana	1.03	0.89	1.67	Utah	0.99	1.10	1.20
Maine	0.81	0.94	1.39	Vermont	0.80	0.87	1.22
Maryland	1.15	1.04	1.09	Virginia	1.02	1.02	1.31
Massachusetts	**0.99**	**0.75**	**0.96**	Washington	1.02	0.96	1.05
Michigan	0.99	1.00	1.06	West Virginia	0.94	0.89	1.34
Minnesota	0.87	0.88	1.15	Wisconsin	0.89	0.78	1.25
Mississippi	0.95	1.07	1.47	Wyoming	0.90	0.87	1.43

Figure 10

This is an analysis of the American Hospital Association Annual Survey data (1999) for community hospitals. Managed care revenue for Medicare and Medicaid are included in the private payer category. Medicare data were estimated using gains and losses as a percent of total hospital costs by payer and state for 1999 from the MedPAC report.

Note: Medicare data for 1999 were estimated by adjusting 1998 ratios using gains or losses as a percent of total hospital costs for 1999.

Source: MedPAC, *Report to Congress: Medicare Payment Policy,* March 2001

ing Group believed there was reason to hope that the situation would improve without extraordinary state intervention, but recommended that the state increase its monitoring of hospital financial conditions.[20] By October 2000, the financial condition of hospitals had deteriorated further and neither significant federal relief on Medicare rates, nor improved private payments, had been forthcoming.

The Finance Working Group recommended that the state increase Medicaid rates and provide targeted assistance for particularly distressed hospitals. The state budget for FY01 included both kinds of assistance. The state had commissioned a separate independent study of the adequacy of Medicaid payments to hospitals. That study, undertaken by The Lewin Group, was presented to the Task Force in September 2001. The discussion of the Lewin Study and Medicaid hospital payment rates by the Finance Working Group is summarized below as part of *Options for Intervention* under the subheading: "Increasing State Funding for Hospitals" on page 32.

As outlined above, since the Task Force's original discussion of hospital financial conditions, some hospitals have improved their financial condition, while others have seen little improvement or further deterioration (see Figure 11 below). For example, in FY01, the median community hospital operating margin was positive for the first time since FY97, although it had not reached a healthy level.

Causes of Continued Financial Difficulty

Revenue Shifts and Low Payment Rates

Some causes of continued hospital financial distress were outlined above under "systemic problems." They include the combined effect of Medicare payment cuts result-

Median Total and Operating Margins: Teaching versus Community Hospitals (FY96-FY01)

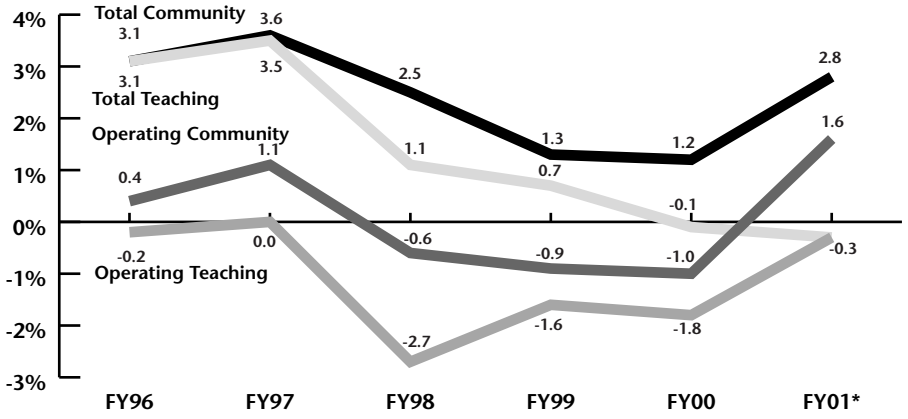

Figure 11

Median hospital margins have remained low for several years. Community hospital median margins have remained higher than teaching hospital medians, although an individual teaching hospital's performance may far exceed that of most community hospitals.

Note: *FY01 based on Massachusetts Hospital Association's data on 60 hospitals. Percent increase or decrease of MHA-surveyed hospitals from FY00 to FY01 was applied to total hospital FY00 data.

Source: DHCFP-403 hospital cost reports

Distribution of Discharges Originating in Chelsea, Everett and Revere

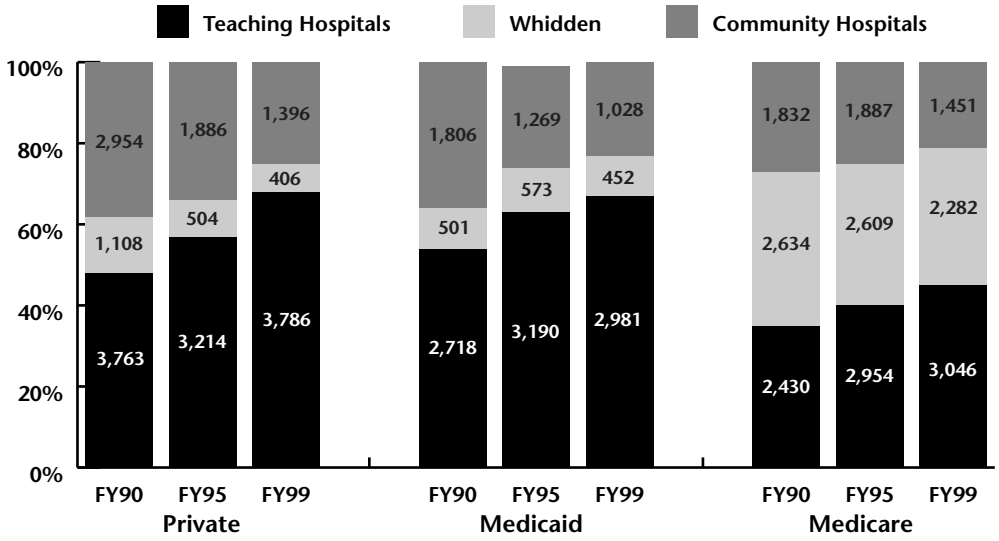

Figure 12

From 1990 to 1999, Whidden Hospital's private pay discharges declined by 63%, Medicare discharges declined by 13%, and Medicaid and other discharges declined by 10%.

Note: Medicaid includes Medicaid, Medicaid Managed Care, Self-Pay, Free Care, Workers Compensation, and other government payers.

Source: Massachusetts Division of Health Care Finance and Policy hospital discharge data set.

ing from the BBA, increased volume in low-paying managed care lines of business, decreased volume in well-paying indemnity lines of business, and Medicaid payments below cost and falling, in relation to costs.

Patient Volume Shifts

Another principal cause of continued financial distress among some hospitals is the effect of patient volume trends that show care shifting from lower-cost to higher-cost settings, particularly in areas where teaching hospitals are geographically a reasonable alternative. Such a shift could cause problems both for the state and for the providers. Since Medicaid payments for many of the services used by Medicaid beneficiaries are related in some way to the cost of care in a particular site, the increased use of higher-cost providers has generated higher overall Medicaid spending. For other services, Medicaid payments are based on average costs statewide, thus higher-cost providers, such as teaching hospitals, could be seeing increasing number of Medicaid patients but experiencing an increase in the gap between their costs and Medicaid revenue.

For some community hospitals, financial difficulty results from an inability to maintain a payer and patient mix that includes sufficient private payment and sufficient volume in well-paid courses of treatment to produce revenue that covers operating costs. The Finance Working Group examined Whidden Hospital as a case study in March 2001 and found significant patient volume declines across the board, but most significantly among younger patients and patients covered by private insurance (see Figure 12 above). The volume that remained was principally comprised of older patients with diagnoses not well-reimbursed by Medicare, high ED volume, and high bad debt. At the same time, teaching hospitals in

the region experienced increases in volume, including anincrease in Medicaid volume. As a consequence, Whidden's financial distress was increased due to its loss of volume, while the teaching hospitals increased their Medicaid volume—reportedly a money losing line of business—which would therefore increase Medicaid losses at those teaching hospitals.

Other community hospitals in regions northeast and southeast of Boston, which the Finance Working Group also examined, also lost younger patients with private insurance to Boston teaching hospitals, but to a lesser degree than Whidden (see Figure 13 below and Figure 14 on page 31). In other parts of the state, community hospitals in close proximity to teaching hospitals experienced similar trends, sometimes for different reasons.[21]

The shift of patient volume away from community hospitals may be due in part to the loss of close ties between physicians and community hospitals—perhaps because physicians that traditionally admitted patients to community hospitals have retired without replacements, or because physicians have realigned their practices after having their assets purchased by teaching hospitals, and/or because community hospitals have become less attractive to physicians and patients for other reasons.

Most Finance Working Group members believe that most of the current number of community hospitals should be sustained because they are important to maintaining

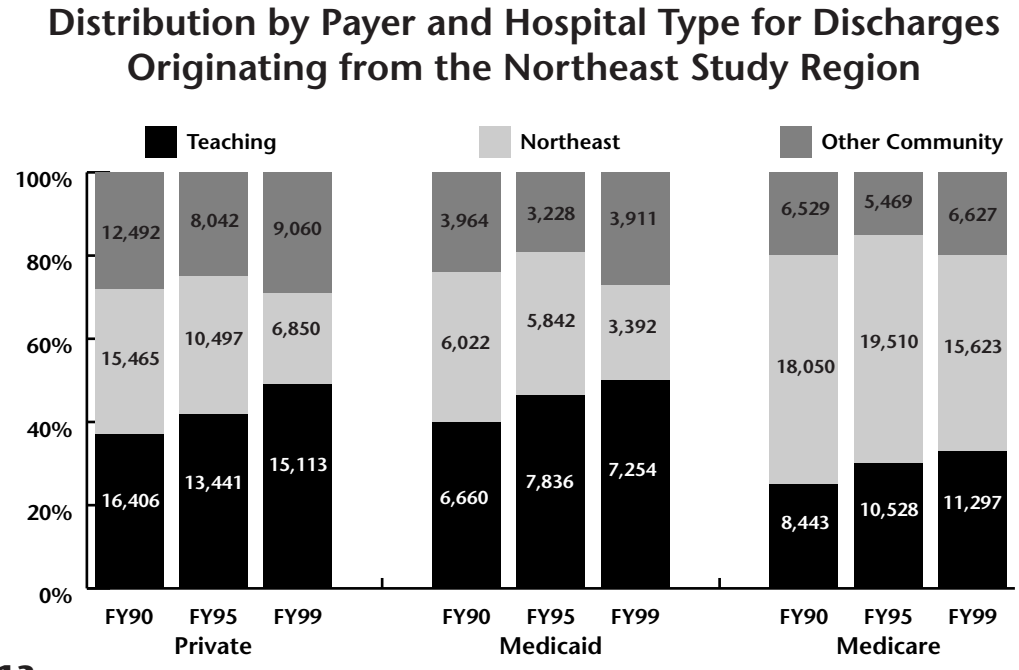

Figure 13

The case study of the region northeast of Boston provides an example of utilization moving from community hospitals to teaching hospitals. From 1990 to 1999 patients from this region used their local community hospitals less frequently and used teaching hospitals more frequently. Some volume also moved to community hospitals outside the region. This trend was particularly evident among private patients.

Note: The study region included the following towns: Chelsea, Everett, Lynn, Malden, Medford, Melrose, Nahant, Peabody, Reading, Revere, Saugus, Stoneham, Swampscott, Wakefield, Wilmington, Winthrop, and Woburn. Medicaid includes Medicaid, Medicaid Managed Care, Self-Pay, Free Care, Workers Compensation, and other government payers.

Source: Massachusetts Division of Health Care Finance and Policy merged discharge and case mix data set.

Percent Distribution by Payer and Hospital Type for Discharges Originating from the Southeast Region

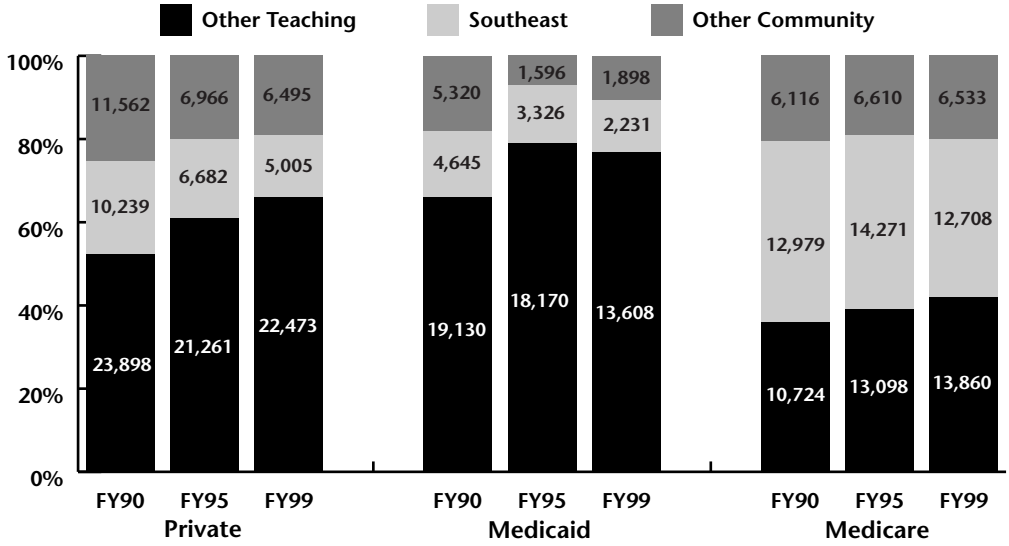

Figure 14

From 1990 to 1999, at the hospitals located in the Southeast Boston study region, private pay discharges declined by 51%, Medicare discharges declined by 2%, and Medicaid and other discharges declined by 52%.

Note: The Southeast Boston study region included parts of the city of Boston (Dorchester, Hyde Park, Jamaica Plain, Mattapan, Roslindale, Roxbury, South Boston, West Roxbury), as well as Braintree, Dedham, Hingham, Holbrook, Hull, Milton, Quincy, Randolph, and Weymouth. Hospitals located in this region include Carney, Faulkner, Milton and Quincy. Medicaid includes Medicaid, Medicaid Managed Care, Self-Pay, Free Care, Workers Compensation, and other government payers.

Source: Massachusetts Division of Health Care Finance and Policy hospital discharge data set

local access to important services, including emergency services, and because they offer a lower-cost alternative setting for many types of care to more expensive teaching hospitals. The Finance Working Group therefore recommended that the state conduct focused studies of the causes of community hospital distress and appropriate interventions.

Cost Increases

Hospitals have experienced very rapid increases in costs that are not recognized rapidly enough by most public, as well as private, payment systems (see Figure 15 on page 32). In particular, labor costs and supply costs have risen rapidly in recent years, but the inflation adjustment factors used by Medicaid and Medicare are at best a year or more behind these growth trends. The Medicaid inflation adjustment is discussed in more detail below. Rapid changes in the use of expensive technologies also pose problems for most formula-based payment systems. This problem is experienced by hospitals nationwide.

Options for Intervention

Options for state intervention to alleviate hospital financial distress include increasing state funding for hospitals, forcing increases in private payments through rate regulation, increasing oversight of and technical assistance to needed hospitals, and more detailed monitoring and identification of best practices.

Massachusetts Acute Hospital Net Patient Service Revenue versus Patient Care Costs (FY94-FY01)

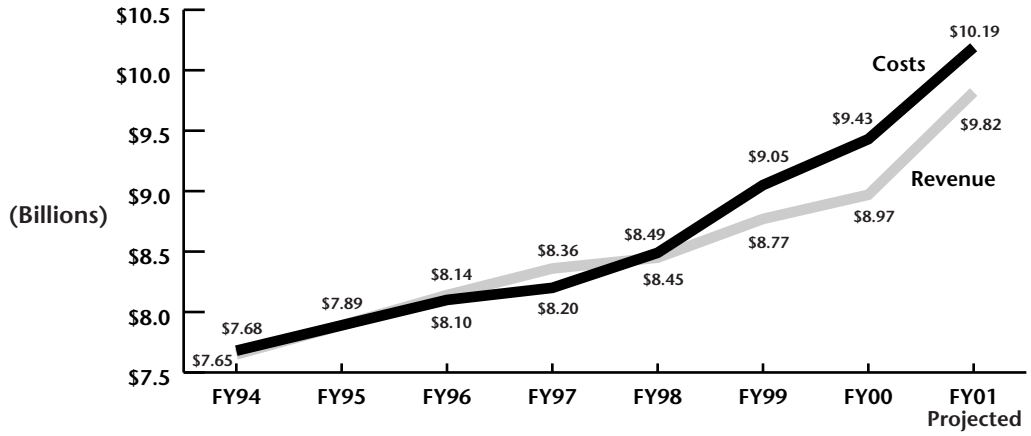

Figure 15

Hospitals' patient care costs have increased very rapidly in the last several years. Patient care revenues have also increased significantly, but have not kept up with hospital costs.

Note: FY01 data are projected based on the Massachusetts Hospital Association's survey of 60 hospitals FY01 data.

Source: DHCFP-403 hospital cost reports

Increasing State Funding for Hospitals

The Finance Working Group supports increasing state funding for hospitals. It also recognizes that to do so thoughtfully, state leaders will need to address several complex questions about the state's role in financing private health care providers and the private health care system, and in providing access to necessary services for low-income people. Clearly the state has maintained and even expanded its role in paying for services for low-income residents through the Medicaid program.

A number of years ago, the state decreased its role in regulating the health care system as a whole, and has instead relied on market forces to shape the development of the health care delivery system. Those forces have reduced excess capacity, but there is now concern that we may be on the verge of reducing the availability of some services to unacceptable levels and of taking out too many lower-cost providers which could increase aggregate costs and lead to access problems. Should the state play a greater role to ensure system stability, and if so, how? In particular, should the state provide additional funding for hospitals? Questions such as these were posed but not answered by the working groups.

Assuming that additional state funding would be available, there are several mechanisms by which additional funding for hospitals could be provided. In addition to increasing Medicaid rates for all hospitals, available mechanisms include relief through the Uncompensated Care Pool and targeted funding for needed distressed providers. Each mechanism would distribute funds in a different way and would benefit different hospitals.

The most appropriate allocation of additional state dollars depends on the relative importance of several policy goals. The Finance Working Group suggests that the following goals should guide decisions

about where the state should concentrate increased funding:

- Fair Payment: Medicaid payment for a particular service should cover a reasonable percentage of the necessary cost of efficiently delivering that service.

- Medicaid Access Preservation: The state's Medicaid policy should work to ensure reasonable access to services for and by Medicaid enrollees.

- System Stability: The state should work to preserve and stabilize the health care delivery system in this time of financial difficulty. This goal does not mean preserving all existing hospitals and their service mixes, but instead means preserving a system that includes the hospitals and services necessary to protect the health of all Massachusetts residents. In light of the high number of hospital closures in recent years and current problems with ED overcrowding and ambulance diversion, the state should carefully assess the impact on access and system costs of the loss of any additional community hospitals.

There is considerable overlap between the Medicaid goals—fair payment and access preservation—and the broader state policy goal of system stability. This is especially true in light of the expansion of Medicaid eligibility that has led to Medicaid coverage of approximately 15% of the state's population. But there is unlikely to be uniformity in all three goals. For example, the state may have an interest in preserving certain lower-cost community hospitals for general public protection and public health reasons, even if they do not serve a substantial number of Medicaid and uninsured residents.

In addition, raising Medicaid rates may not alleviate the financial condition of distressed hospitals (see Figure 16 on page 34). Therefore, Medicaid rates are probably not the most efficient mechanism to use to further the goal of system stability—though the Finance Working Group has recommended that rates need to be increased to further the goal of fair payment.

The Finance Working Group recommended that, in the short term, the state should balance additional state funding among Medicaid rate increases and targeted assistance to further the access and system stability goals. In the longer term, fair payment from all payers is needed to maintain access and system stability; thus, the need for other forms of government relief would decrease.

Fair payment, however, does not mean that the government must pay all costs incurred by providers. The Finance Working Group supports the idea that the Medicaid formula pay for only those costs generated by efficient providers. The notion of fair payment to all providers is consistent with the view of most Finance Working Group members that Medicaid is not a grant program and that payment for services, in general, should support the services of efficient providers.

A useful approach would be to develop a multi-year plan that includes some yearly across-the-board Medicaid rate increases to make up for recent declines in the state's Medicaid payment-to-cost ratio, combined with limited extra Medicaid payments for other factors, and targeted distress relief funding emphasizing system stability and access preservation. Temporary relief from Uncompensated Care Pool assessment obligations is a mechanism to spread some amount of relief to all hospitals in this time of continued financial difficulty. An advantage of this multi-pronged approach is that it allows for immediate state intervention while also allowing additional time for further analysis of appropriate Medicaid payment policy and program changes.

Distribution of Hospital Patient Care Profit/Loss and Impact of an Across-the-Board 10% Increase in Medicaid Payments, by Hospital Quartiles (FY00)

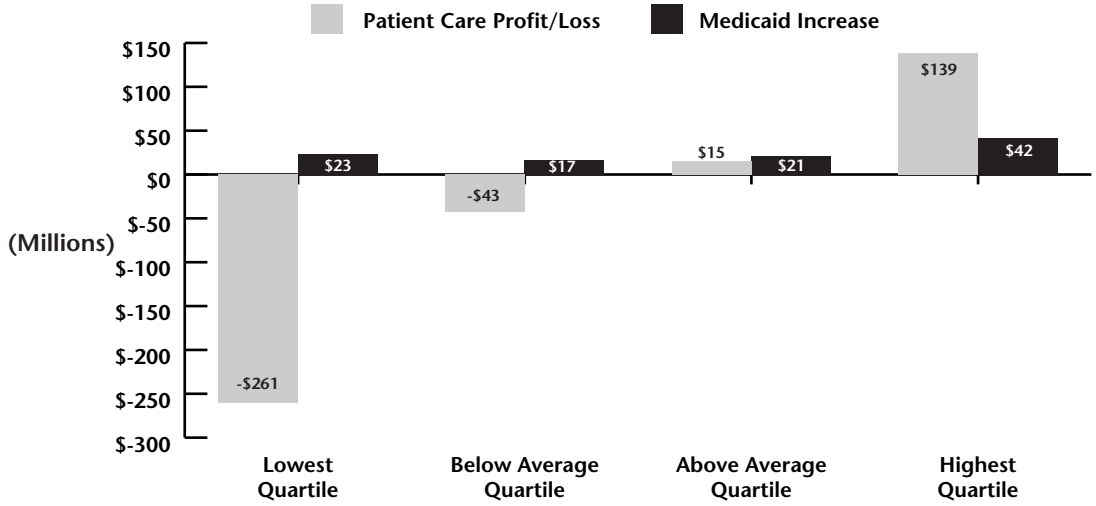

Figure 16

This analysis indicates that an across-the-board Medicaid increase would help financially stable hospitals more than distressed hospitals, and would not substantially ease financial distress for the worst off hospitals. For this analysis, hospitals were ranked by their percent margin on their patient care business and divided into four equal size groups, or quartiles. The light bars represent the total patient care profits or losses for each group of hospitals. The dark bars represent the additional amount Medicaid would pay to that group of hospitals if it implemented a 10% increase in payment rates across the board.

Notes: Medicaid increases were estimated by multiplying .10 by Medicaid net patient service revenues reported on DHCFP-403 hospital cost reports. Boston Medical Center and Cambridge Health Alliance were excluded from this analysis because their Medicaid payments are structured very differently from other hospitals' as a result of their disproportionate share status and their Medicaid managed care programs. Falmouth Hospital was excluded from this analysis because of data issues.

Source: DHCFP-403 hospital cost reports

Medicaid Hospital Payments

The Finance Working Group and the Task Force spent considerable time evaluating the Lewin Report on Medicaid hospital payment rates and the responses of the Division of Medical Assistance. A number of questions were raised in those evaluations that require further analysis and study. Nevertheless, the central finding of the Lewin Report—that Medicaid payments to hospitals are too low in relation to cost, given all other conditions in the system—rings true to most Finance Working Group members. Thus the group recommends that the state provide some immediate increase in Medicaid rates to hospitals. Particularly troubling to the Finance Working Group is the use of an annual update or "inflation" factor that has been below actual inflation, resulting in a growing gap between payments and costs since 1997—precisely the period in which hospitals experienced Medicare payment cuts, decreasing private payment revenue, and increasing Medicaid enrollment (see Figure 17 on page 35). The annual update factor is discussed more fully below.

Despite the important contributions made by the Lewin Study, questions remained that prevented the Finance Working Group from making more specific recommendations with respect to changes in the Medicaid payment formula. Instead,

it recommended further study of hospital costs, cost allocation methods, and the share of costs of efficient hospitals that should be covered by Medicaid. The Finance Working Group also believes it would be necessary to analyze the effects the various changes would have, on a hospital-by-hospital basis.

Further study of "efficiency" and its relationship to costs and payments is warranted. The Medicaid program is legally mandated "to ensure that rates of payment to providers do not exceed such rates as are necessary to meet only those costs which must be incurred by efficiently and economically operated providers in order to provide services of adequate quality." (This language appears in the annual state budget appropriation for the Division of Medical Assistance.) To comply with this mandate, Medicaid program officials must understand whether, and if so, why, the payment-to-cost ratio under Lewin's analysis may be high at hospitals deemed inefficient, or low at hospitals deemed efficient. Either result would prompt concern. In addition, Medicaid officials should consider what the relationship should be between efficiency and the Medicaid payment-to-cost ratio (e.g., should Medicaid cover a higher percentage of costs of efficient providers).

In addition, further study of hospital costs and the state's cost reporting system is recommended. The Lewin Report acknowledged that current cost reporting and cost allocation methodologies make it difficult to ascertain "Medicaid costs." The Lewin Group utilized a prevalent method of allocating costs across payers based on charges. With this calculation, it concluded that Medicaid paid hospitals 71% of their costs incurred in caring for Medicaid patients in FY00. The ratio for inpatient care (81%)

Acute Hospital Payment-to-Cost Ratios for Three Major Payer Types

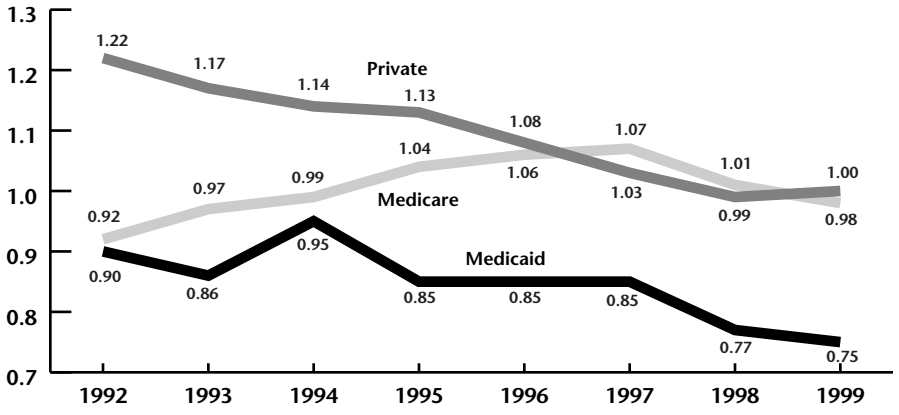

Figure 17

Private payment levels to acute care hospitals declined throughout the 1990s, relative to costs. Payment levels from all three major payers have declined in the last several years.

Sources: Data for 1992-1998 are from The Lewin Group, Inc., *Analysis of the Reimbursement Rates for Acute Hospitals, Non-Acute Hospitals, and Community Health Centers*, June 25, 2001, p.35. All data for 1999 and Medicaid data for 1998 are from MedPAC, *Report to Congress: Medicare Payment Policy, March 2001.*

is much larger than that for outpatient care (58%), according to the Lewin Study.[22] Although questions remain about whether the cost allocation method Lewin used is most appropriate for determining "Medicaid cost" in light of case mix variations, the Finance Working Group finds these low rates to be very troubling.

Thus, the Finance Working Group believes that Medicaid rates should be increased and the state's payment-to-cost ratio should be improved to levels closer to what is paid in other comparable states. The Finance Working Group is not suggesting, however, that Medicaid pay even close to what hospitals estimate are their average costs of care. Hospitals and others have argued that each payer—Medicare, Medicaid, and every private payer—should pay its full "share" of hospital costs. But cost per case varies among hospitals considerably, and the cost-based reimbursement system their argument implies, was abandoned in all states except one.

Hospitals build their cost structures according to what they believe the population in general will need and want, and in an effort to attract privately insured patients. They also incur costs related to business plans that may not yield expected positive results (e.g., the purchase of physician practice assets, or discounted fees for managed care payers). Payers in the aggregate are then expected to provide whatever revenue is necessary to support those costs. Adopting a cost-based payment system, even if only for Medicaid, carries the risk of exacerbating health care cost inflation, which would be problematic for all stakeholders.

Medicaid payment for outpatient services raises a distinct set of problems and questions. Lewin demonstrated that Medicaid payments for these services are far below costs. In part, the Medicaid outpatient payment system is designed to encourage the provision of these services in lower-cost settings such as doctors' offices and health centers. This strategy is consistent with the legislative mandate to pay no more for services than the necessary costs incurred by an efficiently operated provider. If a lower-cost provider could provide the service with quality and clinically appropriate care, it is at least questionable whether Medicaid should be required to pay hospitals a greater amount simply because their costs are greater for the same service.

At the same time, however, this low payment rate has not been successful in redirecting patients to lower-cost sites. Quite the opposite—more outpatient care is provided in teaching hospitals in Massachusetts than in almost all other states. Why? In some areas, lower-cost settings are not available. In others, hospitals appear to have taken steps that may have steered patients away from other providers (for example, by purchasing community-based physician practices and/or employing community physicians directly). Ultimately, the responsibility for directing Medicaid patients to more cost-effective settings rests with the program and it should continue to aggressively pursue this agenda.

Options to address the outpatient problems include increasing payments for those services that must be provided in hospital outpatient departments from a clinical perspective, and advising hospitals expressly that payment for other services will be based on the costs that an efficient provider of a lower-cost provider type would necessarily incur. In addition, care can be steered to lower-cost settings through case management or program rules. For these approaches to be successful, Medicaid payments for lower-cost providers should be adequate to support those providers.

For all services, Medicaid program officials must establish a payment formula that works, in general application and over time, to establish a "fair payment" level, as defined on page 33. The definition of "fair payment" will depend in part on the determination

of necessary costs and efficiency, and also on the role of Medicaid within the larger system. For example, it may be acceptable for the Medicaid program to pay less than the full cost of care provided to Medicaid enrollees as long as Medicaid payments are above the added costs (marginal costs) of providing services to Medicaid enrollees. Such a strategy would require providers to receive higher payments from other sources, if their average costs are above these marginal costs. In the recent past, hospitals were willing to offer their services to other payers (certain private payers) at discounts from their average costs, resulting in significant losses for most institutions. The Finance Working Group expects that over time, this policy will be reversed.

With respect to both inpatient and outpatient services, the Finance Working Group believes that the Medicaid formula should include an update factor that appropriately reflects unavoidable increases in the necessary costs incurred by hospitals. The formula should also include a component that maintains an incentive for efficiency and good management. The current Medicaid cost adjustment factor recognizes general health care inflation using the federal market basket estimates, but limits recognition of labor cost increases to the optimistic projection of the anticipated increase in the consumer price index (see Figure 18 below).

This has produced an annual increase in the Medicaid payment that has fallen further and further behind the costs incurred by Massachusetts hospitals. The Finance Working Group is troubled by this and by the fact that the hospital payment-to-cost ratio for Massachusetts Medicaid is among the lowest in the country. Therefore, the Finance Working Group recommends that the cost adjustment factor be re-examined and adjusted to be more consistent with actual inflation, and with the principles discussed below.

Ideally, an update factor formula would identify the actual unavoidable increases in

Calculation of Medicaid Cost Adjustment Factor for Acute Hospital Operating Expenses

Cost Category	Index Used	Category Weight	Percent Change in Average Price Level	Weighted Percent Change
Labor	Massachusetts Consumer Price Index, Lowest Likely Forecast	71.06	1.40%	1.00%
Non-Labor	16 separate indices tracking items such as rubber/plastic products, prescription drugs, industrial chemicals, processed foods, etc.	28.93	0.53%	0.15%
Sum of Components (FY02 Update Factor)				1.15%

Figure 18

Note: While non-labor prices increased an average of .53%, some indices increased by more than 2%. Others increased at a lower rate, and some decreased.

Source: Massachusetts Division of Health Care Finance and Policy

costs necessarily incurred by efficient providers and would compensate hospitals for those increases. It would also separately identify those elements of overall hospital cost increases that could be lowered through management, and would discount those increases by some efficiency standard. Unfortunately, there is disagreement about whether such a separation of unavoidable and manageable elements of inflation is possible.

One approach would be to attempt, through data collection and analysis, to separately identify the two types of cost increases and to recognize them in two different types of cost adjustment factors. Another approach would be to recognize the different character of cost increases through multiple components in a formula. For example, the Medicare update factor includes an inflation factor intended to reflect the amount inpatient costs are anticipated to rise overall, a productivity factor intended to reflect hospitals' ability to decrease costs by increasing efficiency, and a separate component to account for scientific and technological advancements (see Figure 19 below and Figure 20 on page 39).

A third approach would be to derive an estimate of actual cost increases and apply a hospital-specific adjustment based on how efficient the hospital is compared with peer institutions in the state. In other words, those hospitals judged to be efficient would receive an adjustment equal to actual inflation, while less efficient hospitals would receive a smaller increase. That approach would require a good measurement of efficiency at the outset. The Finance Working Group recommends that the Medicaid program consider these approaches and change its annual inflation adjustment factor to

Medicare Inpatient Hospital Update Factor Recommended by MedPAC (Combining Operating and Capital Payments, FY02)

Component	Percent
Factors affecting the current level of payments:	
Correction for FY00 market basket forecast error	0.7
Unbundling of the payment unit	–2.0 to –1.0
Coding changes across service categories	0
Complexity changes within service categories	0
Medicare policy changes affecting financial status	0
Factors expected to affect provider costs next year:	
Forecast of input price inflation	2.8
Scientific and technological advances net of productivity growth and one-time factors	0 to 0.5
Sum of Components	1.5 to 3.0 (MB – 1.3 to MB + 0.2)

Figure 19

MedPAC uses the methodology summarized in this table to develop its recommended update factor for Medicare inpatient hospital payment rates (operating cost component). MedPAC recommends the update factor to Congress; Congress may approve the recommended update factor or adjust it.

Note: MB is the combined market basket.

Source: MedPAC, *Report to the Congress: Medicare Payment Policy,* March 2001, p. 73

Comparison of Price Indices and Update Factors

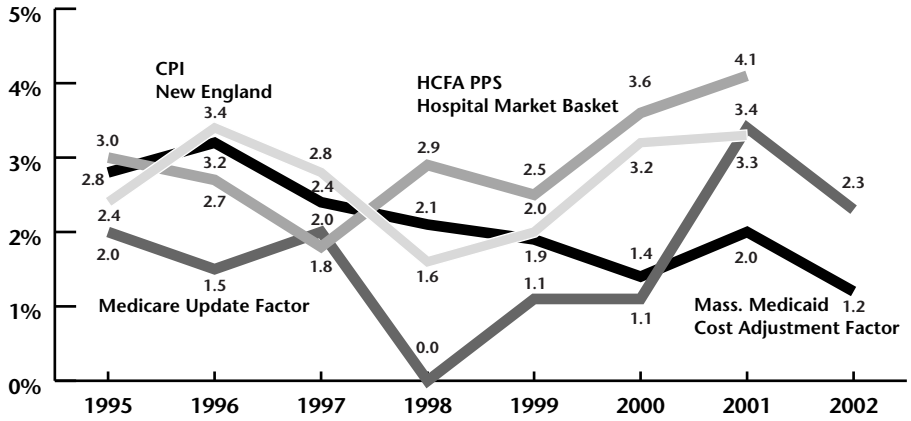

Figure 20

The Massachusetts Medicaid hospital cost adjustment factor declined slowly over the last seven years. During this same period, the HCFA hospital market basket (a measure of hospital input prices) declined slightly and then increased sharply, as did the New England region Consumer Price Index. The Medicare hospital update factor tracked but remained below the hospital market basket, except for a dip to zero in FY98.

Note: The Medicare and Medicaid update factors shown here are for operating costs only.

Sources: Massachusetts Medicaid Cost Adjustment Factor from the Division of Medical Assistance, Medicare Update Factor and HCFA PPS Hospital Market Basket from MedPAC Report to Congress: Medicare Payment Policy, March 2002, and CPI- New England from Standard & Poor's DRI, Health Care Cost Review

appropriately account for inflationary pressures not in the control of hospitals.

Uncompensated Care Pool Reform

The Uncompensated Care Pool is a second mechanism through which additional financial relief may be provided to hospitals. The Finance Working Group has recommended that a detailed evaluation of the Pool's funding and payment systems be undertaken, with attention to the effect that various changes would have on each hospital. The state budget for FY02 includes a provision establishing a special commission on uncompensated care.

Distressed Hospital Funding

In the short term, grants to prevent the closure of certain distressed hospitals or the termination of needed services may be required. The state budget for FY02 includes such funding. Over the long term, systemic changes may alleviate the need for such targeted state funding. Some people argue that special relief for distressed hospitals and other providers counteracts the intended effects of market forces. However, those forces could lead to the loss of services necessary to address the health care needs of the public. Such assistance can also prevent the loss of lower-cost providers that may, over the near term, regain market share as payment for services and distribution of care adjusts over the next several years.

Some Finance Working Group members have suggested that the state should first identify which hospitals are needed and should then direct assistance to those hospitals, rather than creating a program for which all hospitals may apply (which some would say could lead to politically influenced decisions about which hospitals to assist). An alternative would be to make adjustments to reimbursement systems that

would give lower-cost community hospitals access to additional payments similar to those currently benefiting teaching hospitals (graduate medical education payments) and safety net hospitals (disproportionate share payments).

In summary, the Finance Working Group recommends that Medicaid payments to hospitals should be increased as part of an overall relief plan. This relief plan should also include some extra funding for distressed hospitals that are judged to be important to maintaining adequate access to care for Medicaid enrollees and for other state population groups. The Lewin Study recommendations should be evaluated and the Finance Working Group's questions pursued as more lasting changes to the Medicaid program and payment formulas, including the cost adjustment factor, are considered.

All-Payer Rate Regulation

Another option for intervention to stabilize hospitals is to pursue rate regulation as a means of guaranteeing adequate payment from private payers as well as Medicare and Medicaid. This system has the potential of guaranteeing survival of most distressed hospitals, at least in the short term. Longer term, however, it could artificially prolong the existence of hospitals that might not be needed for access purposes, and it could contribute to system cost increases. Also, it would require enhanced cost reporting and analysis and increased health planning. For example, the state would have to determine the appropriate method for counting beds (licensed beds versus staffed beds, for example) and the appropriate number of beds to maintain through a rate-regulated system.

These questions are difficult to answer, but some members of the Finance Working Group believe that the state should move in this direction. A significant obstacle to this approach is the fact that the federal government is unlikely to agree to allow Medicare to be subject to a new state all-payer system. Without Medicare participation, effective rate regulation would be much more difficult to implement.

Increased Oversight, Monitoring and Technical Assistance

The Finance Working Group has recommended that the state increase financial reporting by health care providers and that the state increase its analysis and monitoring of the system. There is disagreement about whether the results of those analyses should be published or should be kept confidential by state officials. Some people argue that reporting individual hospitals' results could precipitate the demise of a hospital found to be in financial peril. Others point out that financial difficulty is generally not secret for long, and that increased transparency of information, similar to that required of publicly-traded companies, will lead to better management and, where appropriate, earlier public intervention.

In addition, the state could identify best practices in hospital management and could assist hospitals in implementing them. A provision in the current state budget directs the Division of Health Care Finance and Policy to publish an annual report identifying hospitals it believes to be in particular distress. The state's experience with this new requirement will inform further policy development in this area.

Intervention to Alleviate Patient Volume Shifts

As outlined above under "system problems," the state could intervene to help alleviate shifts in patient volume toward higher-cost providers. Particularly with respect to Medicaid enrollees, alleviating this shift could have positive effects on the financial condition of both the higher-cost and lower-cost providers, because Medicaid payments are largely based on average provider costs. Of course, care could only be shifted when clinically appropriate and high-quality care is available in lower-cost settings.

An argument against this type of intervention is the notion that markets in which hospitals compete for patients are expected to produce winners and losers, and the "chips" should fall as they may. In addition, efforts to shift patient volume run counter to the principle that patients should be able to choose their providers. One way to pursue this option without directly restricting patient choice would be to forge a partnership between hospitals and the Medicaid program focused on encouraging clients to choose lower-cost, clinically appropriate settings and providers.

Nursing Homes

Financial conditions in the nursing home sector are serious. Even though there is reason to hope that conditions are beginning to improve for some facilities, conditions overall remain financially weak (see Figure 21 below and Figures 22 and 23 on page 42). Nursing homes have continued to close and more are at risk of closure (see Figures 24 and 25 on page 43). Although access to nursing home care appears to be adequate in most areas, occupancy rates in some regions are as high as 97%, and further closures in those areas could lead to access problems. Industry representatives predict that if closure trends continue, there will be no more available beds by January 1, 2003.

Facilities in financial trouble may have even more difficulty than others in attracting and retaining staff, leading to the potential for problems in quality of care. Complaints about nursing care in nursing homes have been on the increase and are a cause for concern (see Figure 26 on page 44).

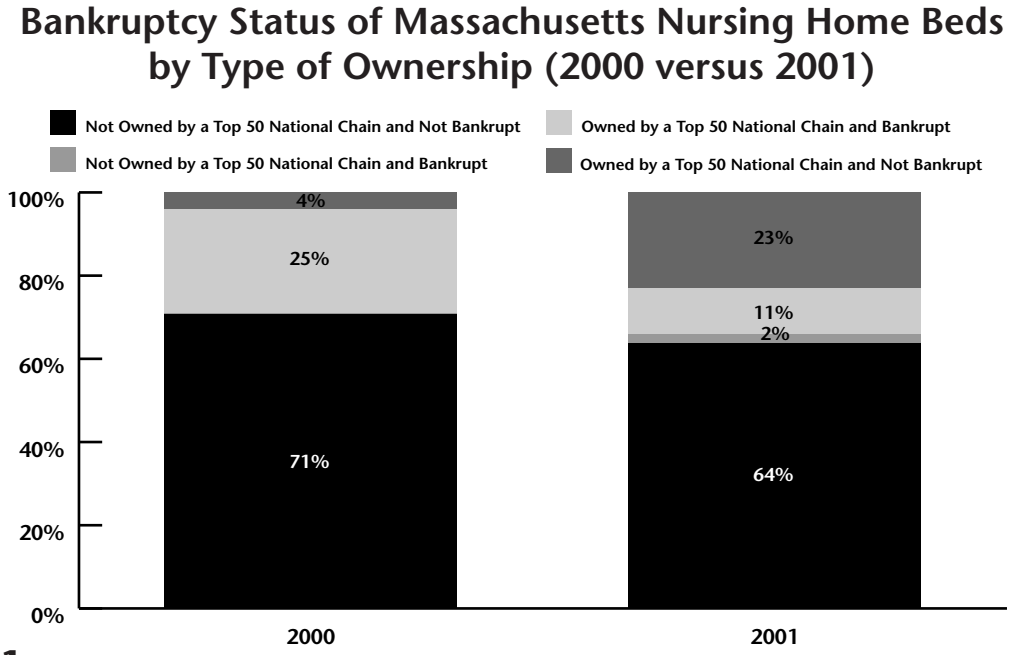

Figure 21

The proportion of Massachusetts nursing facilities in bankruptcy decreased from 25% in 2000 to 13% in 2001. During this period, two large chains, Genesis Health Ventures and Kindred Healthcare (formerly Vencor), emerged from bankruptcy. Others have sold or closed some facilities based in Massachusetts. A few local facilities recently declared bankruptcy.

Source: Top 50 chains from Modern Healthcare, 2000. Ownership and bankruptcy status from the DHCFP-1 nursing facility cost report, Massachusetts Extended Care Federation, and the Massachusetts Department of Public Health.

Median Total Margin for Nursing Facilities Owned by Bankrupt Entities versus Facilities Owned by Solvent Entities

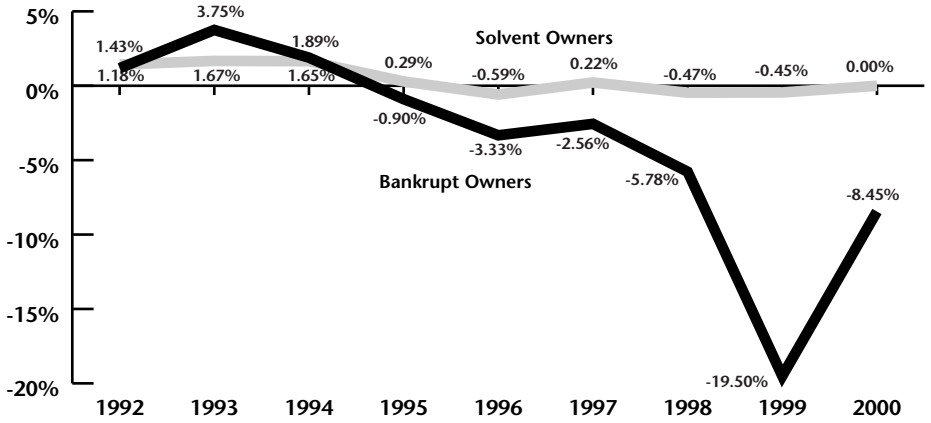

Figure 22

Facilities owned by parent corporations that were in bankruptcy on June 20, 2001 had lower median margins from 1995 through 2000 than facilities with currently solvent owners. The steep decline in 1999 was primarily the result of extremely low margins that year at facilities owned by Sunbridge Healthcare Corporation.

Source: DHCFP-1 nursing facility cost reports

Median Total Profit Margins for Massachusetts Nursing Facilities (1992-2000)

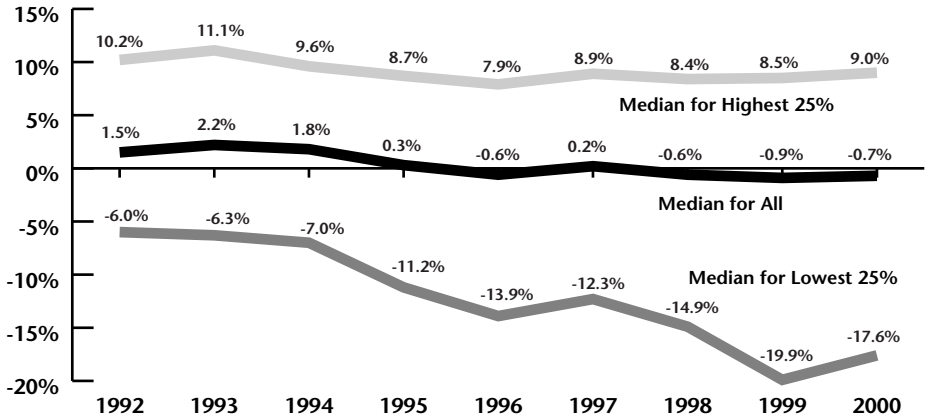

Figure 23

Margins for the top 75% of nursing facilities have remained relatively stable for several years, increasing slightly in 2000. The median margin in 2000 was slightly below break-even. The top 25% of facilities had strong positive margins from 1992-2000. The lowest 25% of facilities had increasingly negative margins from 1992 through 2000, improving somewhat in 2000. The steep decline in margins of the lowest quartile in 1999 is due almost entirely to extremely low margins at facilities owned by one bankrupt chain (Sunbridge Healthcare Corporation); if those facilities are removed, there is little change in median margin for the lowest quartile from 1998 through 2000.

Note: This analysis reports medians, rather than means, which are a better measure of an average facility when the data are very skewed. There are a small number of facilities with very high costs or revenues that would inflate a mean, but not a median.

Source: DHCFP-1 nursing facility cost reports

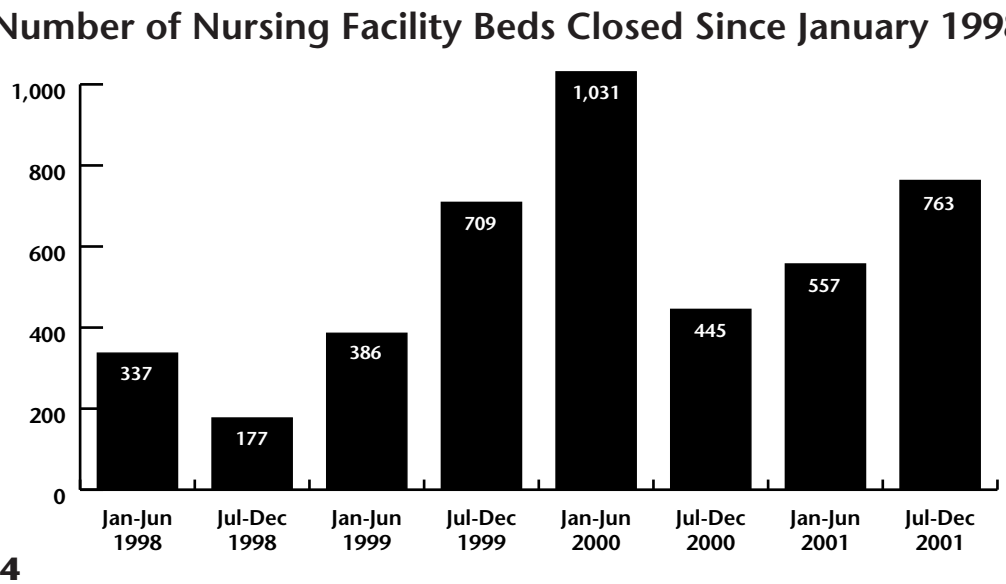

Figure 24

An increasing number of nursing facility beds have closed in recent years, peaking in early 2000.

Source: Massachusetts Department of Public Health

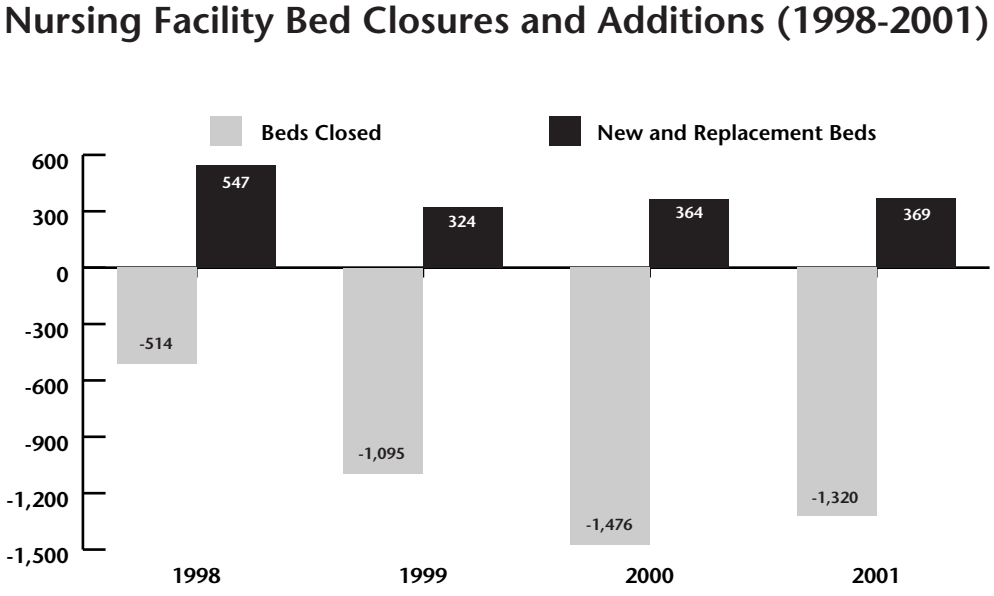

Figure 25

A small number of new beds have become available, even as beds are closed elsewhere.

Note: The reported bed closures are not necessarily permanent. Some closures may result from facility replacement, relocation or renovation.

Source: Massachusetts Department of Public Health

Number of Consumer Complaints About Nursing Service Quality of Care (in Six Month Intervals)

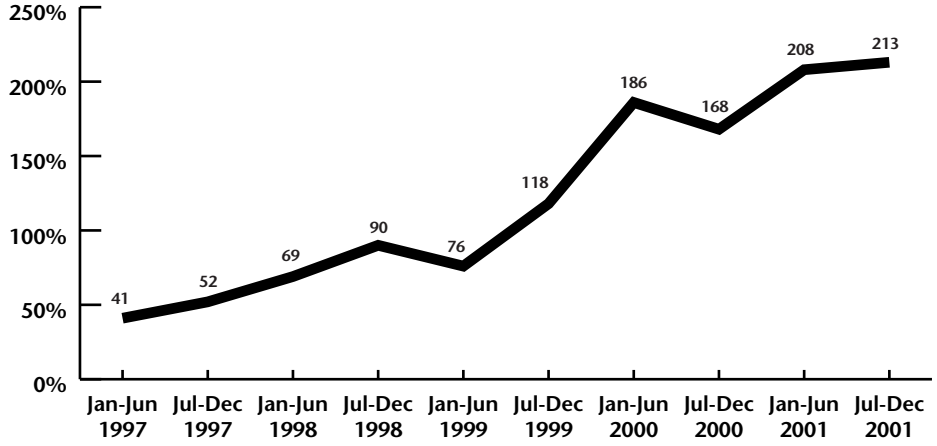

Figure 26

The number of complaints to the Department of Public Health regarding the quality of nursing services at nursing facilities increased dramatically in the last several years.

Source: Massachusetts Department of Public Health

Several factors contribute substantially to financial distress for nursing homes:

- Nationally and in Massachusetts, many nursing homes were purchased in the 1990s by national or regional chains that borrowed heavily to finance their acquisitions. This left those nursing homes with increased debt service and revenue requirements.

- The BBA significantly reduced Medicare payments to nursing facilities. Despite federal "give-back" legislation, Medicare revenue remains substantially below pre-BBA projections (see Figure 27 on page 45).

- On average, Massachusetts nursing homes rely on Medicaid to pay for a higher percentage of their residents than is average for the industry nationally. Medicaid rates are not designed to yield a cushion to subsidize significant changes in conditions and may be lower than the cost a given facility incurs in providing care. With relatively few privately paying residents, Massachusetts nursing homes have little access to non-Medicaid funding.

- Many nursing homes, like other providers, report extreme difficulty in attracting and retaining qualified direct care staff.

- The nursing home industry added almost 8000 beds from 1992 to 1997, anticipating increased demand from the increased number of elderly residents in the state. Demand did not increase as much as expected, resulting in lower industry occupancy rates. The increase in assisted living may have reduced demand for nursing home beds (see Figures 28, 29, 30 and 31 on pages 46 and 47).

Other factors affecting particular nursing homes, exacerbate what are generally bad conditions in the industry. High nurs-

Nursing Facility Payer Mix

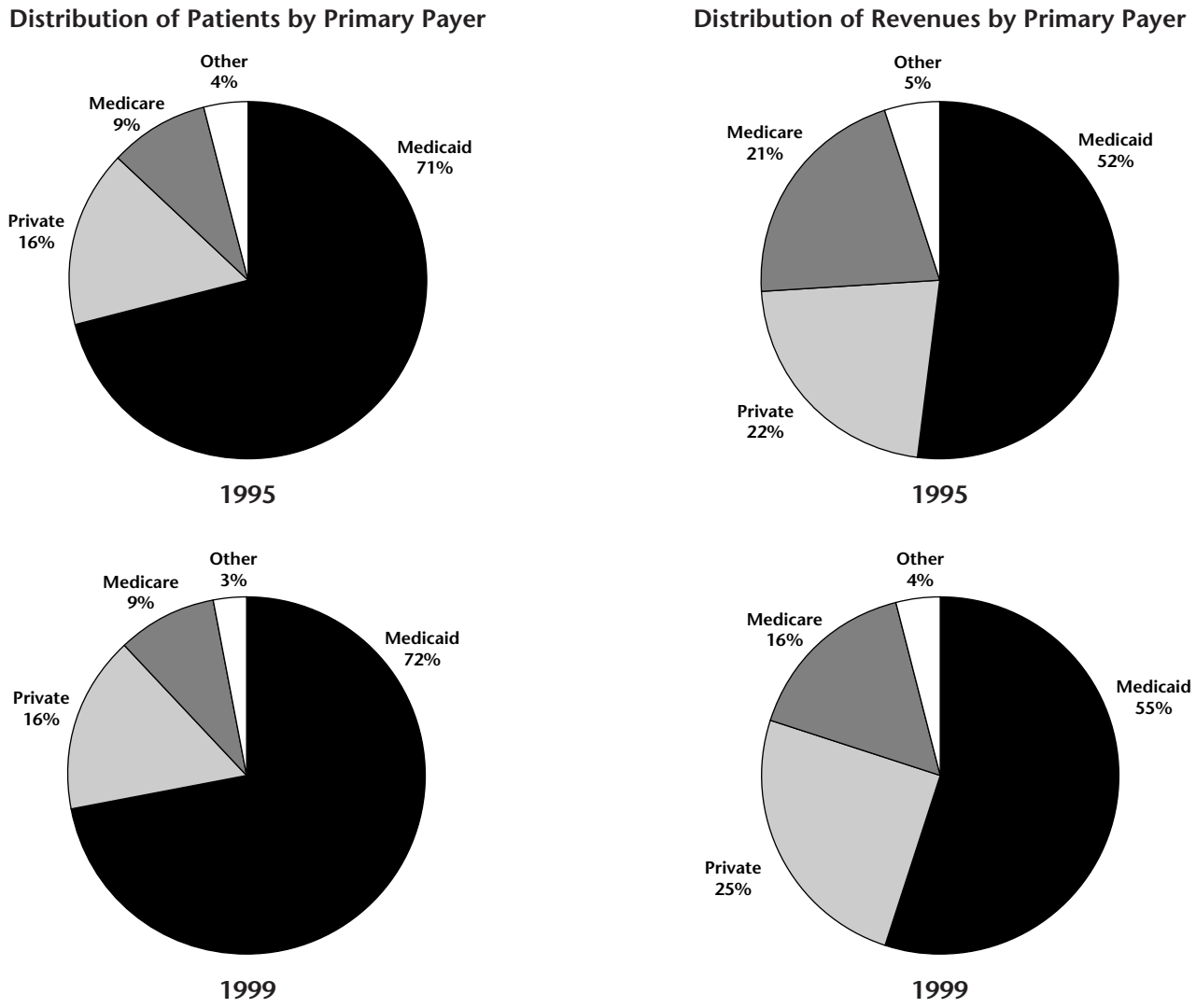

Figure 27

From 1995 to 1999, the share of patients paid for by each of the major payers did not change significantly, however, Medicare's share of total patient revenue dropped from 21% to only 16% as a result of the reduction in Medicare payments to nursing facilities by the Balanced Budget Act of 1997.

Source: DHCFP-1 nursing facility cost reports

ing expense per day is the strongest predictor of low total profit margins. Other significant predictive factors include high percentages of Medicaid-covered residents, low occupancy, a Medicaid rate constrained from increasing by the total payment adjustment, high administrative expense per day, and low patient acuity levels.[23]

The Finance Working Group is concerned that quality of care may deteriorate due to financial pressures and difficulty in attracting and retaining staff, and that access

Average Daily Census Across Massachusetts Nursing Facilities and Total Number of Beds (Industry Totals)

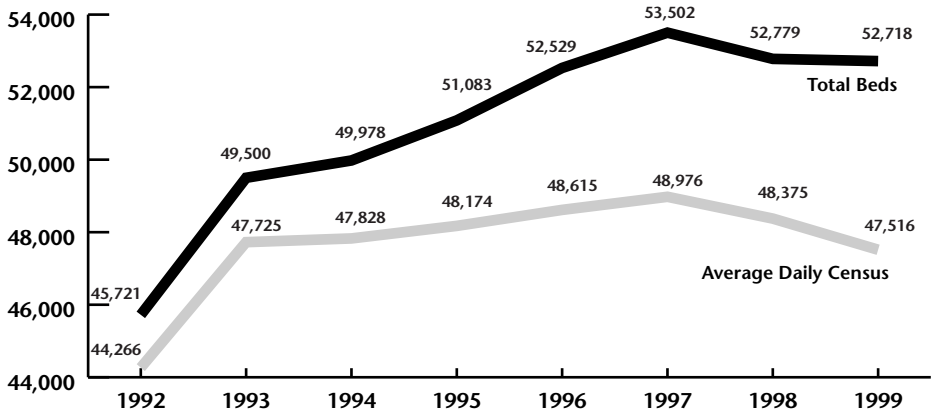

Figure 28

The number of nursing facility beds in Massachusetts increased from 1992 through 1997, with slightly lower levels in 1998 and 1999. The average daily census increased somewhat, but did not keep up with the increased supply of beds; it then declined slightly faster than supply in 1998 and 1999.

Note: Beds do not include transitional care units (TCUs).

Source: DHCFP-1 nursing facility cost reports

Massachusetts Population Over Age 85 (1990-2000)

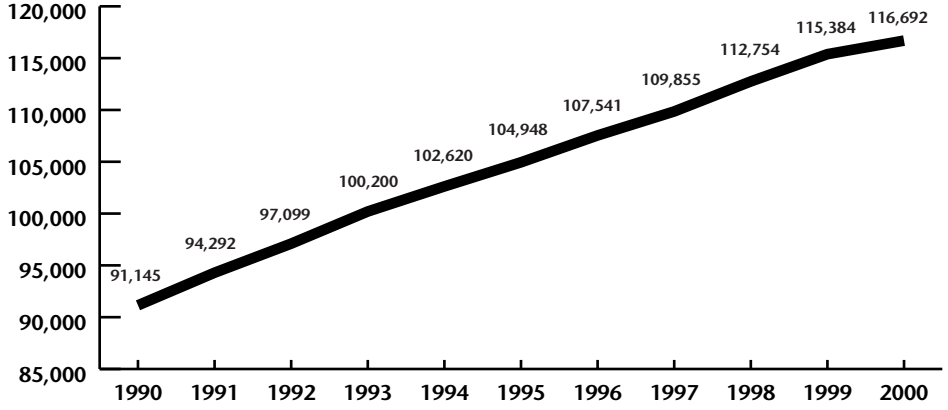

Figure 29

The vast majority of nursing facility patients are over age 85. While the Massachusetts population over age 85 grew 28% during the 1990s, nursing facility patient days increased at a slower rate from 1992 to 1997, and then declined from 1997 to 1999.

Source: US Census data from Massachusetts Institute for Social and Economic Research (MISER)

Industry Occupancy Rates for Massachusetts Nursing Facilities (1992-2000)

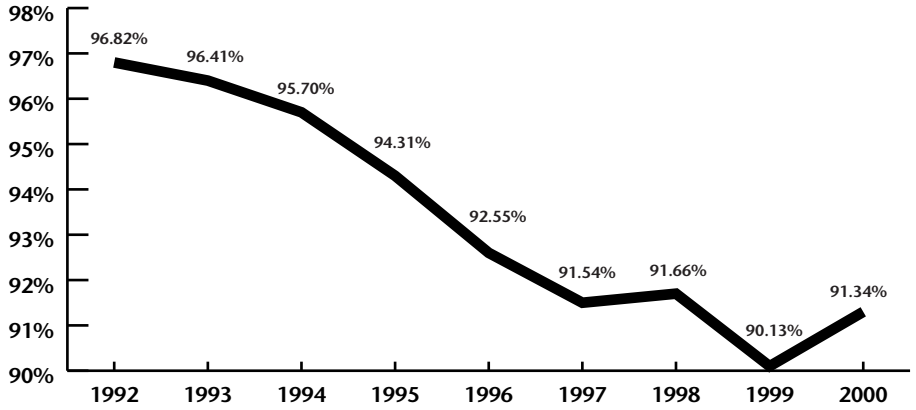

Figure 30

The statewide occupancy rate in Massachusetts nursing facilities declined from 1992 through 1999, but began to rise in 2000 with the closure of a number of facilities.

Source: DHCFP-1 nursing facility cost reports

Massachusetts Certified Assisted Living Units (Approved 1996-2000)

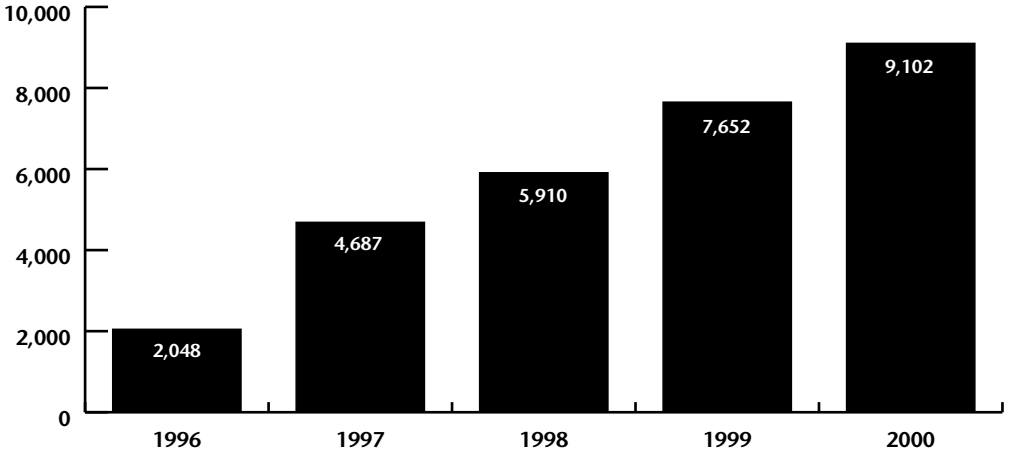

Figure 31

The first assisted living facilities in Massachusetts were approved to open in 1996 and the industry has grown rapidly since then. Units may be single or double occupancy. All units might not be occupied at any given time.

Source: Massachusetts Executive Office of Elder Affairs

may become a problem in some areas if many more nursing homes close in the near future. Some forces contributing to nursing homes' financial difficulties, such as Medicare payment rates and worker shortages, are beyond the state's immediate control. Because Medicaid pays for such a high percentage of nursing home residents' care, Medicaid must play a dominant role in resolving what appears to be an unstable situation.

Options

As discussed more fully below, the Commonwealth's planning and policy development around long-term care should decrease dependence on facility-based care and expand community-based options, over the long term. The principal tools the state has to improve the situation of nursing homes in the near term are state funds (through the Medicaid rate, or special loans or grants), technical assistance, and state regulatory policy. Because of the high degree to which nursing homes depend on Medicaid, and the degree to which Medicaid relies on nursing homes to care for its enrollees, the state bears a special responsibility to engage and work with the nursing homes to avoid serious access and quality problems, and to restore financial stability to the sector.

Medicaid Payments

The state Medicaid program has been moving toward a standard Medicaid rate system based on statewide average recognized costs rather than on facility-specific reported costs. This is generally a sound pricing approach, provided that standard prices are set at a level that is high enough to provide revenue sufficient to maintain an efficient, well-run facility that provides safe, adequate and dignified care for Medicaid patients.

Medicaid should not pay for additional costs that some facilities may have incurred investing in more expensive services used primarily by Medicare patients (who generally require more intensive care) or higher-end amenities to attract privately paying residents. Certain adjustments to standard rates for regional variations in cost and conditions may be appropriate. Substantial Medicaid rate increases across the board or increases that raise rates disproportionately for high-cost facilities would fail to recognize important variations in efficiency, cost and quality, and could even reward bad management practices and fail to reward good ones; therefore the Finance Working Group recommended against this type of increase.

Despite the fundamental soundness of the standard pricing approach, certain features of the rate-setting method and of the method used to transition from facility-specific, cost-based rates to the standard rates should be re-examined. These features include the minimum occupancy threshold, the ceiling on "total payment adjustment," and the relationship between the base year of costs recognized, and the adjustment from base year to rate year.[24]

The Finance Working Group discussed these recommendations in June 2001, and understood that rates proposed for the period January 1, 2002 through June 30, 2002 include a substantial increase in the "total payment adjustment" ceiling, but do not account for the remaining recommendations. The Division of Medical Assistance and the Division of Health Care Finance and Policy have committed to updating the base year of recognized costs for rates as of July 1, 2002. The Finance Working Group recommends re-evaluating the occupancy threshold and the adjustment from base year to rate year, and altering them as appropriate.

A more comprehensive approach to the Medicaid rate issue would be to contract for a study of the rate-setting method to determine whether the standard rates it yields are adequate to cover necessary costs, and whether the rate-setting formula can

include incentives for high-quality care and efficiency.

Targeted Financial Assistance
In the short term, special assistance for particular facilities may be necessary to preserve efficient and high-quality facilities. In the long term, appropriate rate-setting methods should produce Medicaid payments sufficient to sustain these providers.

Increase Private Resources
Although there is disagreement on whether the expansion of private resources in the long-term care sector is likely to succeed, some members of the Finance Working Group believe it is important to explore. For example, if family members were permitted to supplement Medicaid payments to obtain certain amenities for a nursing home resident, the facility would have access to additional revenue. Disadvantages include that such a system could lead facilities to discriminate against residents whose families do not have such additional private resources.

Increase Coordinated Monitoring and Policy Making
The Commonwealth should coordinate more regular monitoring of nursing home financial conditions (e.g., by requiring submission of audited financial statements), of occupancy rates and bed availability, and of alternative care services availability by region. Agencies that regulate various aspects of the nursing home industry should work more closely together to coordinate policy.

For example, capital improvements required by the Department of Public Health for quality of care purposes should be coordinated with capital financing and reimbursement available through Medicaid or other sources. Where monitoring shows that access has become problematic in a particular region, existing restrictions on new beds may need to be lifted, or special programs created to facilitate access to needed services. Bankruptcy should trigger heightened monitoring of quality of care.

Provide Technical Assistance
Identify best practices of efficient, low-cost and high-quality facilities.

Continue Workforce Initiatives
The Commonwealth's workforce initiatives aimed at developing career ladders and wage pass-through funding for direct care workers should be continued, at least in the near term. Additional measures that might ease the workforce pressure include adjustments to licensure and professional practice restrictions.

Long-term Planning

Long-term care planning over time should focus on developing a cost-effective and high-quality community-based continuum of care. A major challenge in this effort will be determining how to develop that continuum of care in light of limitations on available public resources, particularly while nursing home residents continue to rely on facilities for their care.

There is no current capacity to transfer residents of facilities to the community on a large scale, and there will always be some people who require facility-based care. This problem is not new, and it may be particularly challenging for Massachusetts in light of our high utilization of nursing facilities. The Vision 2020 Commission[25] is charged with addressing this and related challenges.

In the near term, state policy makers should do what they can to support community-based providers while maintaining necessary nursing facilities. In the longer term, it will be essential to identify and support more innovative and promising methods of organizing and providing long-term care.

Community-based Providers

Data on the financial conditions, efficiency and effectiveness of many com-

munity-based providers are not readily or consistently available. The lack of consistent and good data inhibits thoughtful state policy and should be corrected through better reporting and monitoring mechanisms. According to reports from provider representatives and available data, financial conditions among community-based providers are generally tenuous.

Community Health Centers

There are 49 Community Health Centers (CHCs) that provide services at 100 practice sites in Massachusetts; 33 are independently licensed and 16 operate under hospital license. Twenty-three, located in designated medically underserved areas, receive direct federal funding. Data presented by the Massachusetts League of Community Health Centers (the League) suggest that, on average, 75% of CHC operations are supported with public funding. Sources include Medicaid, the Uncompensated Care Pool and grants from federal, state and local sources. CHCs are growing and serving increasing numbers of people. According to a report issued by the Division of Health Care Finance and Policy, CHC visits increased by 93% over the last 9 years.[26]

According to the League, a majority of CHCs lost money on operations between 1995 and 1998, and even more did so in 1999. During the same time, 60% of CHCs maintained less than 30 days cash on hand. In addition, salaries at CHCs are well below market. Increasing patient volume and difficulty finding and retaining staff—particularly nurses and dentists—means waiting times are long and growing longer. Despite these difficulties, CHC patient satisfaction remains high. Patients appreciate the patient-centered approach and cultural competence most CHCs offer.

The Finance Working Group believes that the state should explore whether CHCs can offer a lower-cost alternative setting for some of the care now being provided in hospital outpatient departments and emergency departments. Though it is not clear from the available data and the Finance Working Group's discussions with CHC representatives whether CHC services would end up costing less than current rates paid for hospital outpatient services, it seems likely that their costs would be lower, and care, particularly for low-income and language-minority patients, might even be more satisfactory. The Finance Working Group has recommended that the state continue to invest in CHCs and explore the role CHCs can play in redirecting care towards appropriate lower-cost settings.

Among the recommendations offered by the League, which the Finance Working Group believes are worth exploring, subject to availability of resources, are the following:

- Review Medicaid rates and other public payments (e.g., from the Department of Public Health) for appropriateness.
- Lessen administrative costs by reducing rigid contract requirements, and by coordinating state billing, and reporting requirements across agencies.
- Help improve relationships between CHCs and their local hospitals to facilitate movement of care to lower-cost appropriate settings.
- Create a State Health Service Corps to help CHCs attract and retain quality staff (including tuition assistance and loan repayment opportunities).
- Provide resources for technical assistance and upgrading CHC systems.
- Provide grants for urgent needs, deficits and expansion.
- Provide low-interest loans for service expansion.

Home Health Care and Other Community-based Providers

Home health care providers report that, in the aggregate, their annual revenue falls short of their costs by approximately $20-25 million. Medicare payment, which covers 50-60% of home health patients according to industry representatives, declined drastically as a result of the BBA. On a positive note, industry representatives report that home health care providers' experiences under the new Medicare prospective payment system are generally positive, and Medicare revenues are now covering costs. Home health care providers are concerned, however, that Medicare payments are scheduled to be cut by 15% in the near future.

The pediatric home health care system is under particular stress. According to industry representatives, many of the hours of care prescribed by physicians go unfilled due to staffing shortages which are related to low reimbursements and the lack of adequate payments for overtime. Since the Task Force discussions on this issue, some children in need of such services have sued the state, claiming that Medicaid rates are too low to allow adequate access to services.

In addition, chronic underfunding has left home health care providers undercapitalized and, therefore, unable to invest in technology that could increase their administrative efficiency, or in telemedicine equipment that could increase the productivity and effectiveness of clinical personnel. These investments are particularly important since home health care often requires large amounts of paperwork and, like other provider groups, is experiencing staffing shortages.

Other community-based providers such as adult day health providers, assisted living providers, and home care programs working with the Executive Office of Elder Affairs point to financial difficulty and problems in obtaining funding for clients who need their services and who do not have adequate private resources. Their problems appear to result from the combination of limited funding streams, and complicated and restrictive eligibility rules for those funding sources that exist. Ironically, it appears to be easier for some people, particularly those who require skilled care, to obtain Medicaid funding for facility-based care than to obtain home health and home care services that would allow them to remain in the community.

Causes and Interventions

Medicaid Rates and Service Eligibility Rules

Community-based providers believe that low Medicaid rates and, for some, restrictive service eligibility rules, contribute to their financial stress. Medicaid, like Medicare, restricts eligibility for some services, such as home care, to those with the most intensive service needs.

Broadening eligibility would increase program costs and could draw into the program people who are currently receiving the services they need from family members or other informal supports. This might help many people and providers, but would also involve considerable expansion of the Medicaid program, and this seems unlikely in the current fiscal climate.

Nevertheless, Medicaid rates and service eligibility rules should be reviewed as part of an intensive long-term care planning effort. Policies should be focused on encouraging use of the most cost-efficient, community-based care services appropriate to clinical needs.

Alternative Reimbursement Systems for High-Volume Providers

For providers that serve an especially high percentage of Medicaid clients, the state should explore special contractual relationships that allow for alternative reimbursement systems, such as a prospective payment system similar to the new Medicare system.

Grant Programs for Particular Capital Needs
The state should explore whether providing grants or low-interest loans to community-based providers for specific capital needs would increase the efficiency and effectiveness of those providers. The prime example of an area worth exploring is whether the state should assist home health providers in acquiring telemedicine technology. For a minimal amount of money, which would be difficult for these providers to access, great efficiencies could be gained.

Pilot Programs
The state should explore different models of community-based care through pilot programs and demonstration projects. It is likely that different models will be developed that address community needs better in one area than in another. Funding limited programs on a trial basis will help determine which policies work best and will help develop an infrastructure that allows for flexibility.

Coordinate Services and Eligibility Rules
Within the limits of federal law, state-funded and administered programs should be coordinated so that eligibility rules and funding streams do not create barriers to those service plans that are the most efficient and low-cost way of meeting people's needs.

Physicians

Physician practice conditions and incomes in Massachusetts are said to have deteriorated over the last several years primarily due to changes in the nature of physician practices and lack of adequate payment.[27] Despite the increasing amounts of time that physicians must spend on paperwork, returning patient phone calls, research, and patient management, most payment systems still rely on the number of patient encounters as the method for determining physician productivity and sometimes, payment. The benefits that physicians sought in joining larger integrated systems of care—including efficiency and economies of scale in administrative matters and overhead, as well as increased bargaining power with managed care companies—seem not to have materialized in a way that has made physicians' professional lives sufficiently more rewarding or simpler than they were in solo or small group practices.

In addition, payment rates from Medicare, Medicaid and private payers have failed to increase as rapidly as practice costs. Physician income in Massachusetts continues to be lower than in many other parts of the country. Anecdotal evidence abounds that physicians are working harder and harder to support the same level of income. Recruitment and retention of physicians in Massachusetts has become problematic.

Notwithstanding these increasing difficulties, Massachusetts continues to have more physicians per 100,000 population than any other state (and more, of course, than the national average) (see Figures 32 and 33 on page 53). These numbers may not reflect physician availability, as many physicians divide their professional effort among patient care, research and teaching. On the other hand, the many interns and residents in Massachusetts provide large amounts of patient care at teaching hospitals, often working extraordinarily heavy schedules. Overall, the supply of physicians is generally adequate. Certain specialties, such as anesthesiology, radiology, dermatology, and child and adolescent psychiatry, as well as certain geographical areas, are experiencing shortages. There is some risk that Massachusetts may lose its preeminence in the medical field if deterioration in practice conditions and reimbursement persists.

Options

- Medicaid rate increases would help alleviate the physician reimbursement prob-

Number of Non-Federal Physicians per 100,000 Civilian Population (1999)

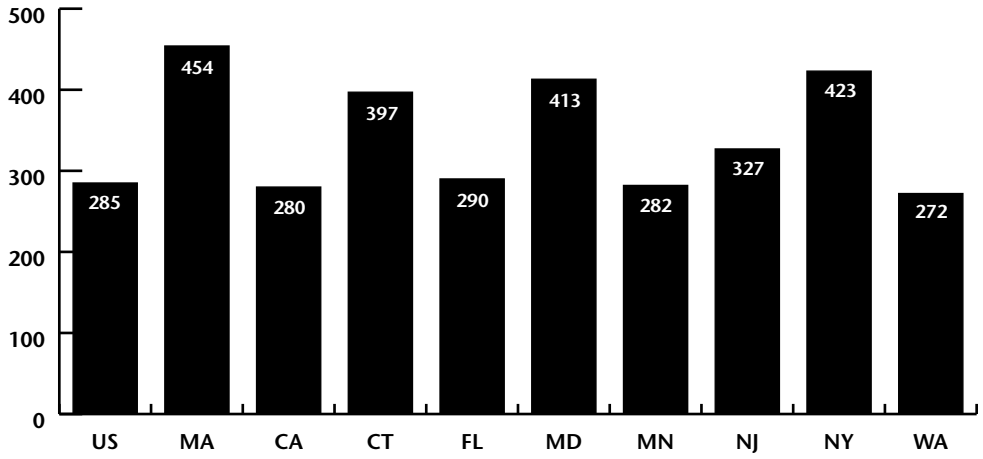

Figure 32

Massachusetts has more physicians per capita than any other state in the nation.

Source: AMA, taken from www.statehealthfacts.kff.org

Number of Non-Federal Primary Care and Specialist Physicians per 100,000 Civilian Population (1998)

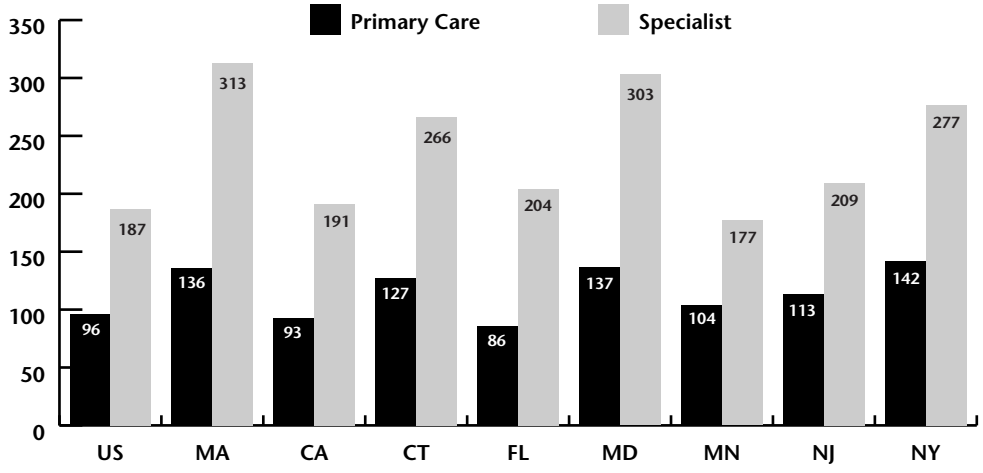

Figure 33

Massachusetts ranks first in number of specialists per capita and third in number of primary care physicians per capita relative to all states.

Source: AMA, taken from www.statehealthfacts.kff.org

lem. As funding is scarce, rate increases could be targeted at services that are most important to Medicaid enrollees (e.g., primary care) and most cost-effective (e.g., community-based physicians as opposed to hospital-based physicians). It may be appropriate to compensate differentially those physicians whose practice has a significant percentage of Medicaid enrollees. With respect to so-called Medicare crossover claims (see Figure 34 below),[28] it is not clear that the Medicaid program should assume the full cost of Medicare allowable fees, particularly in a time of tight financial resources. Ideally, physicians should be able to obtain any difference between the Medicaid payment and the Medicare allowable fee from the federal government.

- The state should also collaborate with physicians to achieve administrative simplification through HIPAA compliance and in the Medicaid program in general.

- New capitation models should be explored, but must include sufficient payment rates and adequate data to support quality and effective management of care.

- As with other sectors, data about physician practice, costs and practice patterns should be collected and monitored.

Examples of the Proposed Medicaid Payment Methodology for Medicare and Medicaid Cross-over Claims

Visit Type CPT Code	Emergency Department Visit 99283		Office Visit, Established Patient, Level 3 99213	
	Current	**Proposed**	**Current**	**Proposed**
1. Medicare Fee 2000	68.09	68.09	52.28	52.28
2. Medicare Payment (.8 * L.1)	54.47	54.47	41.82	41.82
3. Patient Liability (.2 * L.1)	13.62	13.62	10.46	10.46
4. Medicaid Fee 12/1/01	44.27	44.27	46.08	46.08
5. Medicaid Payment	13.62	0	10.46	4.26
6. Total Received by Physician (L.2 + L.5)	68.09	54.47	52.28	46.08

Figure 34

Explanation of Cross-over Claims: Until recently, when a Medicare patient was also eligible for Medicaid, Medicare paid first, and then Medicaid paid the patient's liability (copayment, coinsurance, or deductible). That is, Medicaid acts as a Medigap plan for low income patients. Federal law was recently changed to allow states to limit payments for patient liabilities after Medicare so that the total payment received by the provider from all sources is no more than what Medicaid would have paid if the patient had been solely a Medicaid enrollee. A proposal in the Massachusetts legislature recently implemented this change in Massachusetts. That is, Medicaid will pay as if the patient is a Medicaid enrollee, rather than paying like a Medigap Policy. This is the method currently used by the Medicaid program for Medicaid patients enrolled in private health insurance plans. Note that, under either scenario, providers may not bill Medicaid recipients for the patient liability. The rates paid by Medicaid for physician services are currently under review by the Massachusetts Division of Health Care Finance and Policy.

Source: Massachusetts Division of Health Care Finance and Policy; Division of Medical Assistance

Workforce

Dr. Roderick King, Director of the Boston Regional Office of the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services, and Louis Freedman, Commissioner of the Division of Health Care Finance and Policy, addressed the Task Force about workforce issues in March 2001. Edward Salsberg, Director of the Center for Health Workforce Studies at the State University of New York at Albany School of Public Health, and Robert Shaffner, Director of the Center for Health Workforce Studies at Worcester State College, addressed the Finance Working Group and interested Task Force members in February 2001.

Workforce shortages are creating problems in health care across the country, particularly with respect to nurses, direct care aides and pharmacists.[29] The problem is related to increasing demand, low supply, and also to distribution of workers (see Figures 35 and 36 on page 56). The shortage affects wage costs and, therefore, costs of care. In addition, diversity of the health care workforce is frequently mis-matched to the population served.

Massachusetts has more hospital employees per 1000 population than any other state in the country. Yet most hospitals, and virtually all other health care providers in Massachusetts report that attracting and retaining nurses and other direct care workers is among their most significant and challenging problems. The average age of nurses is rising, and demand for their services far outstrips the supply of nurses in practice and in training.

A variety of factors influence the problem. Use of new technologies and more intensive practice patterns have increased the demand for nurses; working conditions for nurses are making the profession less attractive; alternative positions that draw on their clinical skills but are outside the field of direct care, such as utilization review and quality inspection, are attracting some away from patient care; increased opportunities for women may decrease the number who enter nursing, and the return on the investment of time and money in education may be higher in other fields.

Options for state intervention take three main forms:

Education Strategies
These can be focused on financial support and incentives, such as scholarships and loan repayment programs, or on designing new training programs. The latter can take months and sometimes years.

Job-related Strategies
These efforts would focus on improving working conditions to make nursing and other direct care jobs more attractive, and building career ladders so that more direct care jobs would lead to a professional development path.

Influencing Demand
This type of intervention would involve changing the scope of practice of some kinds of workers so that tasks could be re-assigned, and in some cases the number of one type of professional as opposed to another could be reduced. This strategy would have to be closely tied to quality initiatives to ensure no adverse results from re-assigning duties. This strategy is controversial, however, and has been regarded by some as threatening to quality of care and to maintaining the professional scope of practice of nurses.

Resolution of workforce issues requires solutions that reach beyond the health care sector to involve the academic community, labor unions and public schools. The Commonwealth has enacted a number of programs designed to improve the workforce problem, including a wage pass-through pro-

Increasing Demand for RNs and Change in Hospital RN Employment (1992-1998)

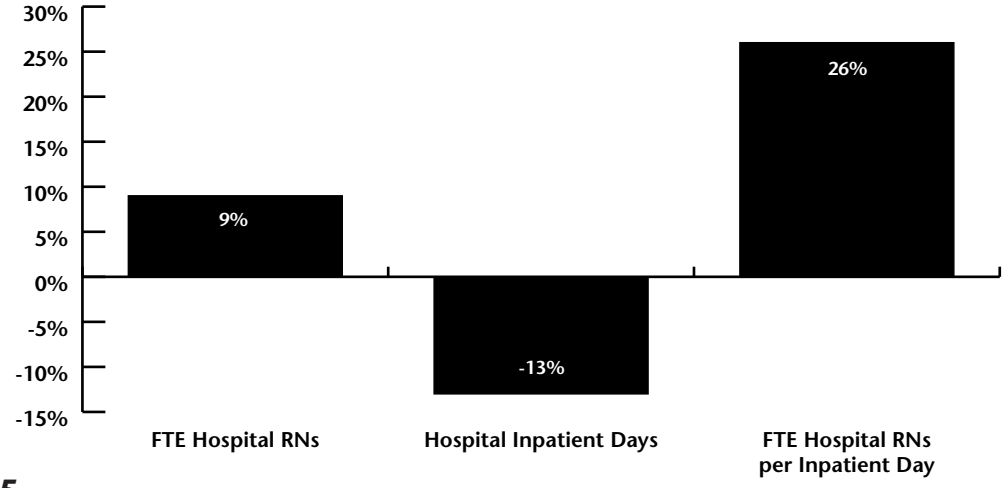

Figure 35

The demand for Registered Nurses (RNs) increased considerably, despite a decrease in inpatient hospital utilization, between 1992 and 1998.

Note: FTE is full time equivalent

Source: Salsberg, Edward S. "State Health Workforce Policies and Planning: Issues, Options and Data Needs," Center for Health Workforce Studies, School of Public Health, State University of New York at Albany, February 2001

Decline in Nursing Graduations in New York (1996-2002)

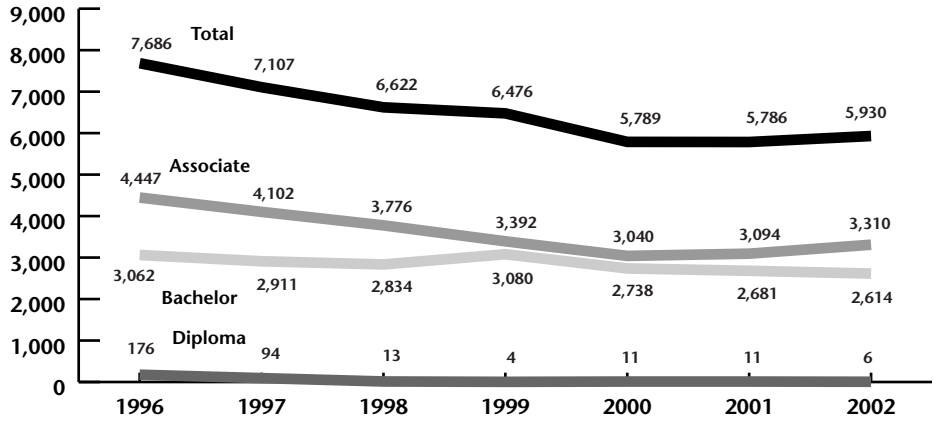

Figure 36

The number of nursing graduates in New York declined from 1996 through 2000 and then plateaued; the trend in Massachusetts is believed to be similar. The increased demand for nurses, together with the decreased supply, has created a nursing shortage.

Source: Salsberg, Edward S. "State Health Workforce Policies and Planning: Issues, Options and Data Needs," Center for Health Workforce Studies, School of Public Health, University of Albany, February 2001

gram for certified nursing assistants working in nursing homes, and scholarship and career ladder programs for certified nursing assistants.[30] Proposals for additional scholarship programs and loan repayment programs have been put forward, but have not been enacted. The level of priority assigned to this problem in the current recession, and the question whether the recession has had an easing effect on the health care worker shortage, remain to be determined.

Prescription Drugs

The phenomenon of skyrocketing prescription drug costs in the United States has been well documented and widely reported (see Figure 37 below). Some of the main features of the phenomenon include:

- The high cost and high utilization of new drugs are more significant factors than increases in prices for existing drugs (see Figure 38 on page 58).
- The benefits of some new drugs over previously available therapies are hard to quantify.
- Utilization of new, high-cost drugs is encouraged by direct-to-consumer advertising, on which drug manufacturers spend increasing amounts of money (see Figure 39 on page 58).
- Access to affordable drug coverage is particularly problematic for seniors, as Medicare continues to lack prescription drug coverage and many employers are cutting back on retiree health coverage (see Figure 40 on page 59).

The November 19, 2001 Finance Working Group report outlines current state strat-

Annual Change in Massachusetts Prescription Drug Expenditures and Boston Regional Inflation Rate (1990-2000)

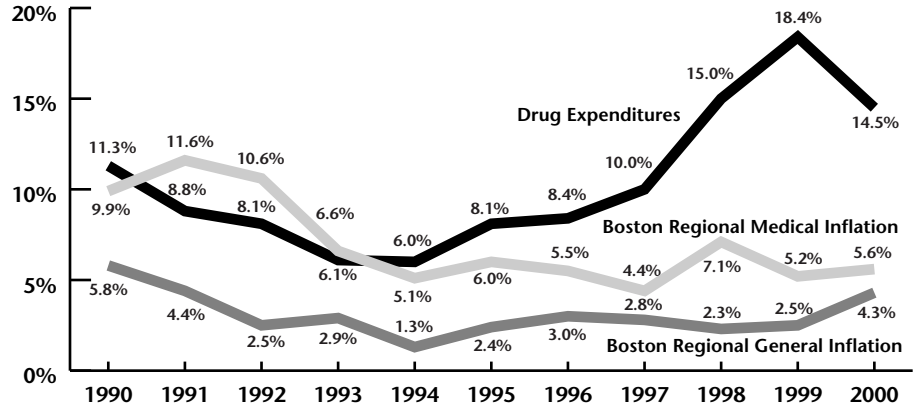

Figure 37

Throughout the 1990s, Massachusetts prescription drug costs increased faster than general inflation; from 1994 through 1998, prescription drug expenditures also increased faster than medical inflation.

Note: Medical CPI and CPI are for the "Boston-Brockton-Nashua, MA-NH-ME-CT" region.

Source: Health, United States, 1999, US Department of Health and Human Services; US and Boston Regional Consumer Price Index 2000, US Bureau of Labor Statistics

Relative Factors Contributing to Rising Prescription Drug Expenditures (1993-1998)

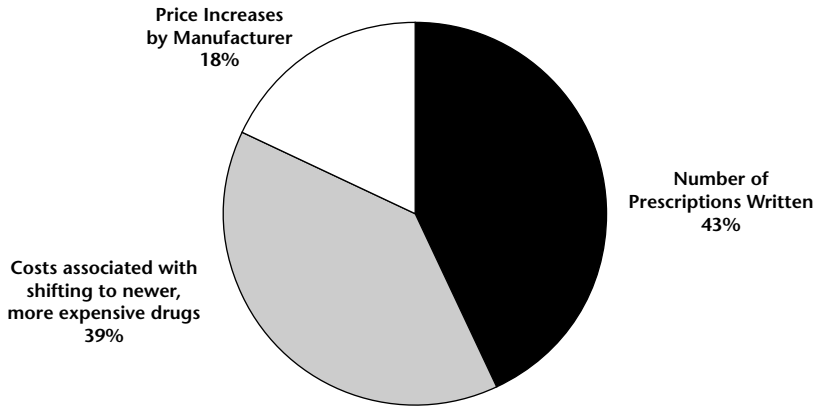

Figure 38

Only 18% of the increase in prescription drug expenditures is attributable to price increases. 43% is attributable to an increase in the number of prescriptions written, and 39% is attributable to the availability of newer and more expensive drugs. Many, but not all, of these new drugs are more effective or have fewer side effects than drugs previously available.

Source: Kreling, David H., et al. *Prescription Drug Trends, A Chartbook*, University of Wisconsin-Madison and the Kaiser Family Foundation, July 2000

Total Direct-to-Consumer Promotional Activity Spending by Drug Manufacturers (1994-1998)

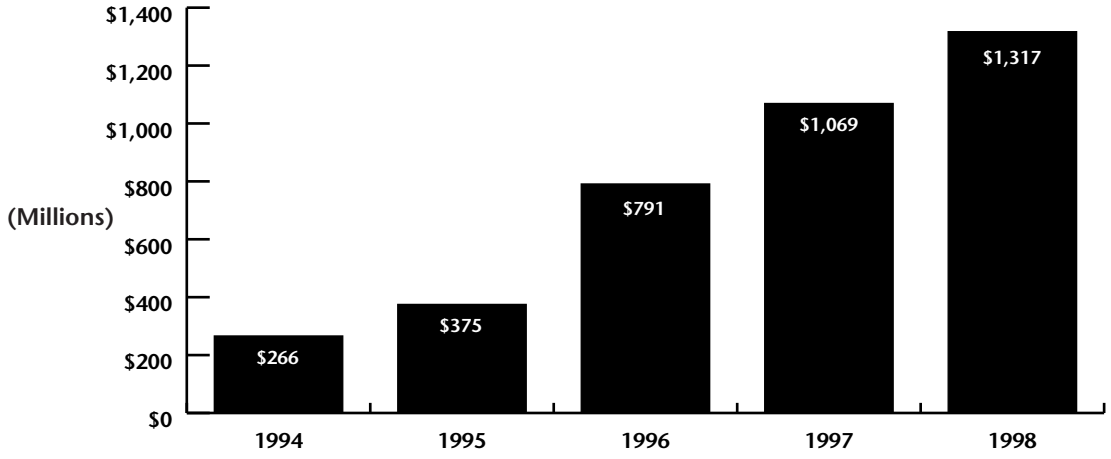

Figure 39

Drug manufacturers' spending on direct-to-consumer promotional activities increased rapidly after the US Food and Drug Administration revised guidelines for advertising prescription drugs in 1995.

Source: Kreling, David H., et al. *Prescription Drug Trends, A Chartbook*, University of Wisconsin-Madison and the Kaiser Family Foundation, July 2000

Blue Cross and Blue Shield of Massachusetts Medex Gold and Medex Bronze Annual Premium Rates

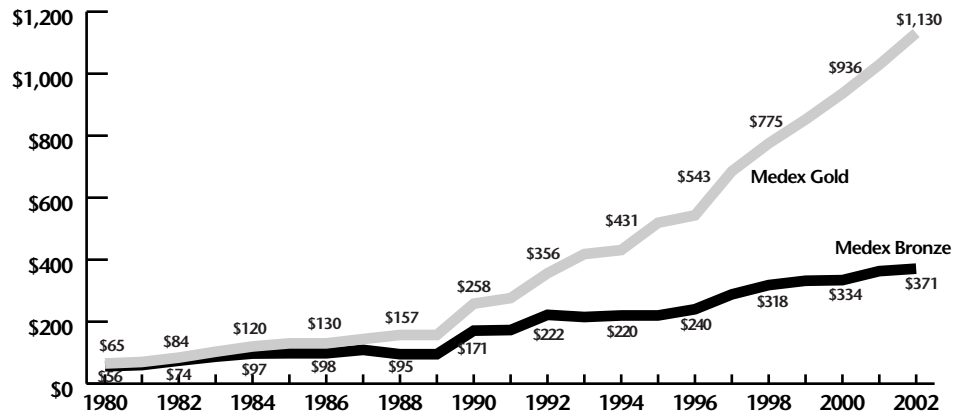

Figure 40

Blue Cross and Blue Shield's Medex Gold and Medex Bronze Medex plans are identical, except that Medex Gold includes drug coverage and Medex Bronze does not. Medex Gold premiums are increasing much faster than Medex Bronze.

Source: Massachusetts Division of Insurance

egies for increasing access to prescription drugs and controlling cost increases.

Options for more aggressive state action in the prescription drug arena include mandatory price controls, and establishing the state as a wholesale purchaser of drugs for all residents and health plans. The state could also explore the possibility of establishing a single-payer type of insurance plan for prescription drugs, in which participation by health plans would be required. Although ultimately, intervention from the federal government will probably be required to achieve significant savings on prescription drugs, exploring alternative state plans is recommended.

HMOs/Insurers/Payers

The Task Force's analysis of financial conditions in the private insurance market focused on the state's four largest HMOs, which cover the largest portion of residents who are covered by state-regulated insurance. Many residents are covered by self-insured employer plans governed by the federal government pursuant to ERISA.

Four major concerns guided the Finance Working Group's discussion:

1. The need for enhanced HMO financial strength through increased reserves and positive operating results;

2. Discomfort with the disparity between premiums paid by small groups and individual enrollees, and premiums paid by large groups;

3. A belief that premiums in general should be "affordable;" and

4. A belief that payments to providers should be timely and adequate.

The Finance Working Group acknowledged that these general concerns are in tension with one another and that too much emphasis on any one of them could exacerbate problems involving one or more of the others. For example, while premium increases appear to be necessary to improve health plan solvency and to pay for the rising cost of care, those increases may also increase the number of people without health insurance. Now that all four major health plans have positive margins, more emphasis may be placed on other concerns (see Figure 41 below). Health plans are at the center of many pressures exerted by stakeholders in the health care system: employers and other payers want to keep premiums affordable, providers need adequate payment, and consumers want access to services and providers at low or no additional cost.

More specific problems are outlined in the Finance Working Group's report on this issue. The Finance Working Group recommended, in general, that the state pursue the following strategies:

- Enact legislation establishing minimum net worth and risk-based capital requirements consistent with national standards.

- Require that plans report financial results by line of business, that they file reports using statutory accounting rules as well as Generally Accepted Accounting Principles, and that they report on ASO (Administrative Services Only) business and enrollment.

- Explore approaches to increasing oversight of risk-sharing arrangements and risk-assuming providers to ensure that providers have the operational capability and the financial resources to manage the

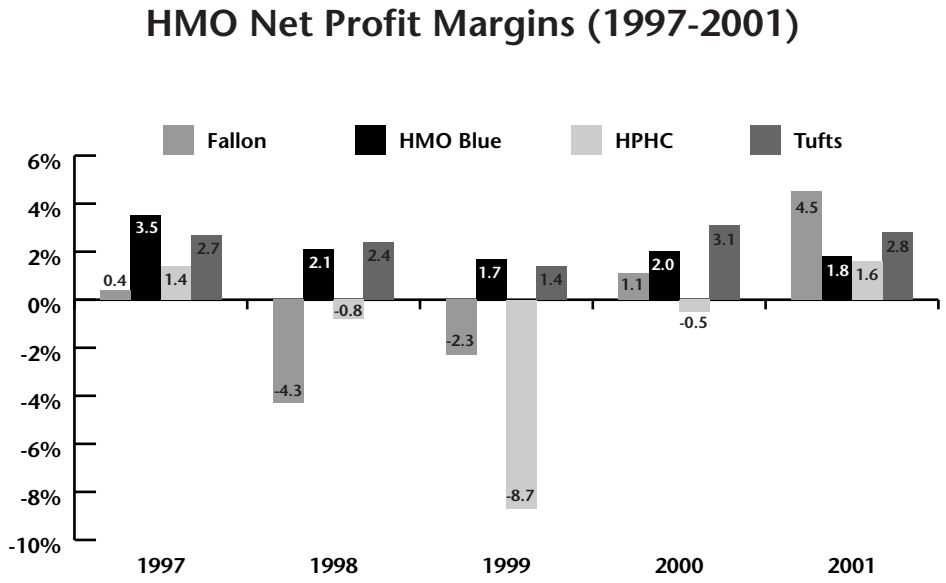

Figure 41

Fallon had negative margins in 1998 and 1999 and Harvard Pilgrim Health Care (HPHC) had negative margins from 1998 through 2000. All four major health plans had positive margins for 2001.

Source: Massachusetts Division of Insurance

risk assumed and that the financial terms of the arrangement are reasonable.

- Consider new mandates, including mandated benefits and reporting requirements, in relation to any premium increases these mandates will require.

- Enact legislation giving the Commissioner of Insurance authority to oversee certain major transactions of HMOs, such as sales of substantial assets, mergers, and expansion into other states.

- Explore the possibility of requiring that premiums be certified as actuarially sound by an independent analyst.

Since the Task Force discussed this issue, the financial condition of our largest HMOs has improved to the point that all four experienced positive margins in 2001. Although there has been no new legislation in response to these recommendations, the Finance Working Group believes that there is continued need for increased oversight of, and authority over, health plans in Massachusetts.

Employers

After several years of little or no increase in health care coverage costs in the mid-1990s, employers have experienced several years of significant increases in premium costs (see Figure 5 on page 13). While the economy flourished and employee retention was an important goal, many employers did not pass on much of the annual premium increases to their employees. In a strained economy with diminished corporate profits, this approach is unlikely to be sustained. The main challenge on which employers are focusing is controlling the rate of increase in health care costs.

As costs have begun to increase rapidly again in the post-managed care backlash era, employers have re-engaged in the search for ways to improve the efficiency and effectiveness of the health care system. Some strategies involve employers assuming more control over plan and provider network design. Most include increasing consumer responsibility for, and control over, care decisions and costs, and aligning incentives for physicians to direct care to the most efficient providers and weed out unnecessary care.

The main tool supporting these strategies is information—about quality, cost and efficiency of different providers and different treatment options. Information is being coupled with financial incentives for consumers and providers. In addition, employers are exploring lower-cost self-insured alternatives to commercially available managed care and insurance products, and are developing strategies for incenting providers to use resources more efficiently and reduce medical errors. More detail on the options being pursued is available in the November 19, 2001 Finance Working Group report.

Consumers

Many employers and others believe that consumers must be engaged more actively in the effort to reduce overall health care costs and slow cost increases. Trends show that consumers have been choosing more expensive providers and prescription drugs. Yet most people are unhappy with the high cost of health care coverage, which is driven in part by their choice of provider and treatment.

Some members of the Finance Working Group do not believe that consumer incentives are likely to affect choice of provider, because most people choose the provider their physician suggests. Other Finance Working Group members are optimistic that a combination of consumer financial incentives, physician financial incentives, and intensive education of both consumers and

providers about relative cost and quality of providers will lead to changes in patients' choices of providers and will slow the rate of health care cost increases. Decisions about appropriate policy changes will have to be made based on an assessment of who is really driving provider choice. In either case, however, more reported information about provider quality, cost and efficiency would help patients and physicians make decisions. Reporting efforts based on this principle should be supported.

Endnotes for III: Sector Financial Conditions and Related Challenges

20. As noted above, the Commonwealth followed this recommendation by granting in the FY02 GAA specific authority to collect financial information more frequently.
21. In 2001, Attorney General Thomas Reilly issued a report on market conditions in greater Springfield, pursuant to a legislative directive (Section 93 of Chapter 236 of the Acts of 2000) that resulted from allegations that a community hospital had been inappropriately excluded from the network of one of the region's largest HMOs.
22. During FY00, Medicaid covered 14% of hospital patients and contributed approximately 10% of hospital revenue statewide.
23. This analysis has been updated since it was presented to the Task Force at its June 25, 2001 meeting, and the results are somewhat different. Details of the regression analysis are included as an appendix to the June 25, 2001 report on long-term care in the supplementary volumes.
24. These features are discussed in greater detail in the June 25, 2001 Finance Working Group report to the Task Force. Briefly, the occupancy threshold merits re-examination in response to industry representatives' claims that due to increased patient acuity and decreased lengths of stay, more flexibility is required than was the case when the threshold was set. Most nursing homes are not able to meet the threshold. The update factor merits re-examination for the reasons discussed under the heading "Hospitals." The ceiling on total payment adjustment merits re-examination because it adversely affects efficient and historically low-cost providers—precisely those the state should try to preserve.
25. This group was created in line item 9110-0100 in the FY02 General Appropriation Act (GAA).
26. Source: Massachusetts Division of Health Care Finance and Policy, *Massachusetts Health Care Trends: 1990-1999*, October 2000.
27. Due to the lack of hard data on many aspects of physicians' quality of life, the Finance Working Group has relied on physician representatives' descriptions of trends.
28. The term "Medicare cross-over claims" refers to the patient-responsible amount for patients who are eligible for both Medicare and Medicaid. Because the two programs have different fee schedules, the question arises whether Medicaid, which pays for the patient-responsible amount, should use its own fee schedule in determining the amount to pay (as it does for other Medicaid enrollees who have access to other insurance) or whether it should use the Medicare fee schedule in determining the amount it will pay. The issue is illustrated in Figure 34.
29. It is unclear whether the current economic slow-down will have a positive effect on the health care workforce shortage. The state and federal government should monitor the situation and try to create opportunities for people who become unemployed to ease the worker shortage in health care.
30. The FY01 General Appropriation Act (GAA) included $35 million to fund increases in wages and related employee costs over 2000 levels for certified nurses' aides (CNAs) in nursing facilities. In addition, $5 million was appropriated for a career ladder grant program in long-term care and $1 million for a CNA training scholarship program. The FY02 GAA included $40 million to fund increases in wages and related employee costs over 2001 levels for CNAs in nursing facilities. It also continued funding the $5 million career ladder grant program and the $1 million CNA training scholarship program.

IV: The Future of Health Care Policy Analysis in the Commonwealth

Reflections on the Task Force Process

The Task Force, through its working groups, succeeded in finding facts and identifying forces and trends affecting the Massachusetts health care system and its financial stability. One of the most important functions of the Task Force has been to provide thorough background and understanding of the health care system to the state leaders who convened it. The combination of analysis and reports by the working groups and invited guests along with discussion and commentary by thoughtful participants and stakeholders in the health care system performed this function well.

The Task Force did not find or recommend comprehensive solutions to the problems of high aggregate cost, provider financial performance disparities, or the appropriate structure of regulatory oversight and state intervention. It also did not provide firm recommendations in a number of areas. These outcomes, disappointing to some, are to be expected in light of the complexity of the system and the lack of agreement that comprehensive system reform is needed. In addition, the members of the Task Force who are direct stakeholders in the system understandably view proposed solutions from their own interested perspectives. Therefore, the solution most Task Force members could agree on most readily was that more money from the state would help. On more challenging questions such as achieving administrative simplification through adopting some common type of information system, which would inevitably cost some participants more than others, agreement could not be reached.

In addition, the Task Force has not addressed all the items listed on the topical agenda for 2001 in the Task Force Interim Report. Time and resources limited our inquiry. These items still merit detailed consideration:

- The Uncompensated Care Pool (soon to be addressed by a Special Commission on Uncompensated Care, pursuant to section 74 of Chapter 177 of the Acts of 2001).
- The role of health care in the Massachusetts economy (together with projections of the effects that various interventions, and failure to intervene, may have on the economy).
- Access to health services by region.
- Mental health, which the Finance Working Group strongly recommends be assigned to a separate focused working group.
- Dental care.
- The role of the Determination of Need program.

The Interim Report highlighted the need to discuss several questions, the answers to which may change over time. Those questions, and several points that may be useful in considering what the answers may be, are as follows:

1. What is the appropriate role of competition among providers and insurers? Does Massachusetts have enough providers and insurers to enable competition to play an effective role? Should providers or insurers be maintained for competitive

reasons, even if it requires intervention with taxpayer dollars?

2. What is the appropriate role of state health planning? Should the state determine which facilities are needed to preserve access to health services? If so, what agency, person, or group should be the decision-maker? How would decisions about whether a particular provider is "needed" be implemented?

3. How much is too much to spend on health care in Massachusetts? At what point will our health care costs dissuade businesses from locating here?

In some ways, the last question should be answered first, because it sets the limits within which the state must set health care priorities. Of course, there is no specific threshold at which businesses will choose to locate elsewhere or will relocate outside Massachusetts based on health care costs, but trends in this area should be monitored. Employers are already exploring lower-cost alternatives to commercially available insurance plans. Some have relocated portions of their operations to other settings. The degree to which health care costs have influenced those decisions is not clear, but the state should investigate the question.

Even if employers do not relocate, it is reasonable to expect that they will shift more health care costs to employees as those costs continue to increase—particularly while corporate earnings are low. Some will drop coverage altogether. It is reasonable to anticipate that rates of uninsurance will rise.

There is a threshold at which the cost of health care coverage will place it beyond the reach of too many Massachusetts residents. The effects of that situation on providers, on the health status of residents, on the state's attractiveness a s a business location, and on the political viability of major health care reform are not yet clear, but they are likely to become more clear unless strategies for constraining cost growth can be implemented.

The first and second questions outlined above relate to one another and will affect state leaders' analyses of the appropriate actions to take with respect to the health care system. Competition plays an important role in encouraging efficiency, but it may also be related to the regional shift in patient volume towards teaching hospitals.

For example, teaching hospitals purchased community physician practices in part to position themselves to compete for global managed care contracts. The resulting change in physician alignment and practice patterns is likely a force in the shift of inpatient volume away from community hospitals. That trend may be driving up system costs and contributing to premium increases. In turn, those increases are likely to lead to increases in uninsurance.

There may be instances where providers or insurers that are faltering should be maintained, even if it requires the use of public funds for a period of time to determine whether they can be restored to stability or whether the system can adjust to their absence without an unacceptable loss of access to services. A remaining challenge is to find ways of instilling in each market participant an incentive to improve efficiency of the system overall.

There is an increased role for state involvement in health care, at least with respect to data collection and monitoring of financial conditions and access. There is disagreement on whether the state can and should determine which facilities are "needed" and which are not. State agencies are already coordinating more than in past years, and they will need to continue to work together to determine appropriate interventions when providers threaten to close or terminate essential health services.

Recommendations for the Future

The Finance Working Group had several advantages: its topic was based on data and analysis, even if subject to variable interpretation; its members were not directly representing providers and insurers whose financial distrlowess led to the creation of the Task Force and the Working Groups; and it included a cross-section of academics, former regulators, and consultants who were familiar with a variety of aspects of the health care system.

The Finance Working Group suggested several versions of an ongoing analytical group to assist state policy makers in the executive and legislative branches. To add slightly more detail to that recommendation, the Finance Working Group suggests that such a group should have the following features:

Mission

- To educate leaders and the public on trends and conditions in the health care system;
- To perform and report analysis that sheds more light on the conditions of and trends in the health care system.

Function

- To mediate (i.e., to facilitate communication of data, interpretation and views on issues) between and among government, the public, and the health care delivery and financing systems;
- To understand, communicate, and go beyond the vested interests and views of system participants to advise government on the system as a whole.

Authority

- Advisory only, not regulatory. The group should, however, have a specific audience and expected reporting venues, such as hearings or public meetings of a larger more formal group.

Mandate

- To report on conditions and trends in the health care system based on data that are collected by the government or made publicly available;
- To report periodically on a small number of predictable issues—for example, reviewing the Medicaid annual update factor, regular review of levels of uninsurance in Massachusetts, and other specific metrics defined by state leaders;
- To comment on particular issues as requested by the Governor or Legislature;
- To monitor, analyze and report on linkages and connections between parts of the health care system—especially those that may not be monitored and reported on by a particular constituency (e.g., monitor nursing home bed closures and occupancy rates, determine whether they correlate with numbers of hospital inpatients awaiting nursing home placement and high hospital occupancy rates);
- To present reports, according to a set schedule, to a larger health care forum including political leadership, health agency commissioners and observers (including legislative health care committee staff).

Membership

- Ten to fifteen people with health care experience and expertise; include a minority of state agency representatives (e.g., Attorney General's Office, Division of Health Care Finance and Policy, Division

of Medical Assistance, Department of Public Health);

- No private sector members who are currently serving in or representing providers or insurers; direct stakeholders should be represented in a larger discussion forum that responds to the smaller analytical group.

Duration

- Should be time-limited, but long enough to allow for continuous monitoring of trends. The Finance Working Group suggests five years, subject to renewal.

Audience

- A health care forum similar to the Task Force (including political leadership, high-level officials and private sector stakeholder representatives), though a smaller group might allow for easier discussion and interaction; the forum would meet approximately quarterly to hear and discuss reports from the analytical group.

Models from other states, the federal Medicare Payment Advisory Commission, and past experiences in Massachusetts (e.g., the Hospital Payment Advisory Commission which existed in the mid-1990s) should be reviewed for helpful lessons. When examining models that have not worked particularly well, state leaders should assess whether current conditions differ from those that prevailed at the time or place in question, and whether changing certain features might lead to a more constructive model.

The Finance Working Group continues to believe that such an ongoing public/private analytic effort would be useful at this time as the state reassesses its role with respect to regulation of and intervention in the private health care system, and protection of the health care safety net. The working groups and the Task Force have served an educational purpose and provided a forum for communication about the health care system.

Continued analysis and communication between public and private stakeholders will be essential as conditions continue to present challenges to public and private leaders in health care. An ongoing group whose mission transcends that of any existing agency in health care and whose members include people from the private sector would provide a structure and framework for that continued analysis and communication.

Appendix: Health Care Task Force Member Submissions

Health Care Task Force Member Submissions

1. Baystate Medical Center
2. DeNovis
3. Health Care for All
4. Lahey Clinic
5. Massachusetts Association of Health Plans
6. Massachusetts Extended Care Federation
7. Massachusetts Hospital Association
8. Massachusetts League of Community Health Centers
9. Massachusetts Medical Society
10. Massachusetts Nurses Association
11. Service Employees International Union

Baystate Health System
Springfield, Massachusetts 01199

February 11, 2002

Massachusetts Health Care Task Force Co-Chairmen
c/o Mary Beckman
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, MA 02108

Dear Mr. Co-Chairmen:

Thank you for the opportunity to serve on the Health Care Task Force and to provide you with Baystate Health System's comments on the draft staff report of the work of the task force.

Throughout the report, staff makes reference to the trend which is described as care shifting from lower cost community hospitals to higher cost teaching hospitals with the need to create incentives to shift care back to lower-cost, clinically appropriate providers in order to ensure that the system remains "functional and affordable". This analysis over simplifies the issues driving the financial crisis in health care. Massachusetts is privileged to be home to a number of world-renowned teaching and clinical institutions each of which is unique in its facilities, service capabilities, and its relationship with its surrounding communities. Significant cost and quality of care differences do exist across the state, but it is much too simplistic to suggest that it is a community hospital versus teaching hospital phenomenon. Baystate Medical Center is the flagship teaching hospital of the Baystate Health System and the only teaching hospital in the four county Western Massachusetts area. Baystate Medical Center enjoys a cost structure, which is significantly lower than eastern Massachusetts' teaching hospitals, and at the same time it serves as the inner city hospital with the largest inpatient Medicaid population in the state. Baystate Medical Center provides inpatient care to 35% of the regional market with 65% of the care being provided by other area hospitals. This is quite different from the eastern part of the state where a significantly higher percentage of care is provided by the Boston-based teaching hospitals.

A single statewide approach which does not recognize the unique attributes of our existing health care delivery system – its providers, insurers and geography - threatens to reduce the quality of care that our citizens have grown accustomed to without addressing the underlying costs which are of concern to all of us. The failure of a one-size-fits-all approach to health

care regulation of the 1980's should be a lesson on the minds of every member of the Task Force as the Commonwealth considers another round of health care policy-making.

Another issue, which is not adequately addressed in the report, is significant demographic factors such as the aging of the baby boomers, cultural diversity and the increasing number of the frail elderly, all of which will place an increasing burden on the existing system. This increasing volume, coupled with new and more expensive technologies, pharmaceuticals, and biotechnological advancements will inevitably consume more resources both public and private. Therefore, any solution to today's problems must anticipate these changes in order to be more than just a short-term fix.

In conclusion, I want to recognize the accomplishments of the Commonwealth. We have provided health care coverage for 250,000 more of our poorest and most vulnerable citizens through Medicaid expansion, implemented health insurance programs that provide every child in the state with health care coverage, provided seniors with a guarantee of affordable prescription medications, and we have a history that supports the best teaching hospitals in the world. These are accomplishments that our citizens and elected leaders can view with pride. The Commonwealth has displayed the wisdom to provide more and better health care for its citizens. Now let it have the courage of its convictions and fully fund the services that it has created and prepare for the inevitable growth in the health care needs of our citizens.

Sincerely,

Michael J. Daly
President
Baystate Health System, Inc.

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deNovis

February 13, 2002

Justice Herbert Wilkins, Chairmen
Professor Stuart Altman, Ph.D.
Co-Chairs, Health Care Task Force
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, MA 02108

Dear Justice Wilkins and Professor Altman:

deNovis, a Massachusetts company dedicated to dramatically simplifying the administration of health care through the use of information technology, has been honored to participate on the Health Care Task Force and on the Administrative Simplification Working Group, in particular. The Task Force has made a significant contribution to creating a common understanding of the health care issues that face that Commonwealth.

We would like to take this opportunity to comment on the Draft Final Report to the Task Force from the Co-Chairs and Working Groups. As noted in the Administrative Simplification Working Group's segment of the Report, there was much discussion on the issue of setting new, higher performance standards for the administration of health care in the Commonwealth.

deNovis put forth specific higher performance standards for the Working Group to discuss and mechanisms for the Commonwealth to test these standards. While the mechanisms proposed (demonstration projects and centers of excellence) were included in the Draft Final Report, the standards were not. The purpose of these standards would be to hold provider and payor organizations accountable for their administrative performance, to identify opportunities for meaningful change, and to "raise the bar" with regard to administrative simplification initiatives.

Instead, the Draft Report suggests that "the Massachusetts Health Data Consortium (MHDC) lead the effort to, with its collaborative operations and information officer's forums, to agree on performance standards." The Administrative Simplification Working Group Final Report envisioned MHDC would provide these recommendations to a Health Care Efficiency Review Panel, "which would then determine whether to adopt or change any of those proposed standards." The Health Care Efficiency Review Panel was to be comprised of Health Care Purchasers – Employers and State Government. deNovis recommends that the Final Report retain the structure of the Administrative Simplification Working Group Final Report recommendation whereby MHDC would propose standards to a Health Care Efficiency Review Panel comprised of Health Care Purchasers.

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deNovis

Technology to support these standards is available today. And not just from deNovis. There are several other companies, several based in Massachusetts, which offer technology solutions that can bring about the critical changes we all desire.

Externally validated analysis of the standards conclude that payors in the state can reduce their administrative costs by 25-50% while improving medical care through real-time access to critical health information. This adds up to approximately $1 billion in resources freed up annually in the Commonwealth for state government, employers, providers, consumers and health care companies.

We understand that payors and providers and the State are stretched due to HIPAA efforts, business cycle resource constraints and bioterrorism preparations. This, however, is just the time that demonstrates most pointedly the shortcomings of our current approach to heath care administration. In this information age when over a billion transactions are processed on the stock exchange every day, a significant portion of the core administration of health care is still processed manually. As we all know, manual administrative processes breed inefficiency, inaccuracy, poor customer service and medical mistakes. We believe now is exactly the time to make small investments to capitalize on the information technology breakthroughs coming to health care.

We know some think they have heard this all before. But, when there is the very real potential to achieve significant administrative cost savings and simplification, not to mention improve day-to-day medical care and prepare for new health care threats, we believe it is important to move swiftly forward with the recommendations of the Working Group.

By developing standards through the Massachusetts Health Data Consortium and the Health Care Efficiency Review Panel, sponsoring demonstration projects and supporting Centers of Excellence, Massachusetts can set a new standard of health care administrative excellence to match its reputation for medical care and research.

We look forward to working with you, and all of the state health care leadership, to bring about these important improvements in the administration of health care in Massachusetts.

Sincerely,

Jerilyn Asher
Chairman

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HEALTH CARE FOR ALL

February 11, 2002

Professor Stuart Altman, Co-Chair
Judge Herbert Wilkins, Co-Chair
Governor's Health Care Task Force
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, MA 02108

Dear Professor Altman and Judge Wilkins:

Health Care For All believes that the fundamental problem with our health care system is the lack of universal coverage. Many of the other problems that plague the system result from this inadequacy. While we think that a comprehensive national solution is the best way to achieve the goal of universal coverage, the federal government is not going to provide leadership on the issue at this time. Massachusetts has made significant incremental progress in improving access to care that must be continued, particularly in a period of economic downturn, when unemployment increases. Our "agenda for action" provides concrete proposals that move us toward the goal of a more rational and equitable system for all residents of the state.

Although we have made recommendations about each of the major issues facing the health system in the Commonwealth, we are distressed by the Commission's lack of attention to issues related to access to health care, as well as the weaknesses of its recommendations in this area. The concerns of thousands of Massachusetts residents who have inadequate or no health coverage have been short-changed in this process. The issues of hospitals and insurers have dominated the proceedings. The problems of the uninsured were not sufficiently factored into the overview. We believe, to some degree, this is the result of the lack of a broad consumer representation within the Commission.

It is regrettable, although perhaps inevitable, that no consensus for action has emerged from our deliberations. Nonetheless, action is needed. The problems that gave rise to the Commission—institutional instability, rising costs, and the everyday struggles of too many residents of the Commonwealth, who lack access to affordable, quality care, remain. In addition, since the Commission began its deliberations, the combination of recession and state and federal tax cuts have both increased the demand for public sector support of the system while simultaneously eroding the ability of the state or federal governments to respond. We believe it is possible to make incremental progress in addressing all of the problems that plague our health care system. With this in mind, we offer the following action agenda to you and our fellow Commission members.

Respectfully submitted,

Robert Restuccia
Executive Director

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An Agenda for Action
Presented by Health Care For All
To the
Massachusetts Health Care Task Force
2/11/02

Access

Preserve existing programs

Our first priority must be to preserve eligibility and benefits for those who are currently on MassHealth and other public health insurance programs. We can and should be proud of the progress we have made in recent years in reducing the ranks of the uninsured. We need to act decisively to prevent that progress from eroding during this economic downturn. Failure to act will only deepen our current recession and further destabilize our health care delivery system. Generally, cuts in eligibility or benefits not only shift costs onto those who are unable to pay, they also have unintended (if not unexpected) consequences including lost federal reimbursement and shifting care delivery to more expensive settings. It is critical to remember that MassHealth overall has been an extremely sound strategy for meeting the needs of Massachusetts residents, while greatly benefiting the state budget, providers and payers by bringing in federal reimbursement, reducing demand by the otherwise uninsured on the Free Care Pool, funding hospitals, physicians, health centers, and nursing homes, and even generating local resources through Municipal Medicaid.

New cigarette tax funding will be needed to maintain the existing MassHealth expansion programs implemented in 1996/7. At the same time, the Commonwealth should actively pursue other revenues as well as avenues to enhance revenues and reduce spending. One such avenue is to maximize federal reimbursement for programs that are currently funded 100% with state dollars. Health Care For All has taken the lead in advocating this approach to help offset state costs for the Prescription Advantage program and we are pleased to learn that progress is being made on that front. But we have also learned that the Commonwealth is not taking full advantage of the availability of federal funds for other programs (e.g. Healthy Start and perhaps others). A renewed aggressive effort to maximize federal reimbursement is needed.

Another avenue is to reduce payment for improper claims. The Commonwealth should invest in reducing its claims error rate, take further steps to improve Third Party Liability recovery, and invest additional funds (matched by the federal government) in Medicaid Fraud Control. (Additional action agenda items are presented in the "Cost" section)

Address the needs of the low-income uninsured

The success of our access programs for children shows that we can achieve near universal coverage, at least on an interim basis, without an individual or employer mandate and without significant "crowd-out." What is lacking is the political will to put a set of programs in place for adults similar to the ones we have for children. Such an initiative would expand MassHealth eligibility to the poor residents of the Commonwealth not currently eligible. The remaining low-income uninsured would be eligible for a program that parallels the Children's Medical Security Plan in providing access to primary care, limited prescriptions, and other benefits. This limited benefit package would help the remaining uninsured access primary care and thus reduce emergency room utilization and preventable hospitalizations without undermining existing private sector coverage.

The "Health Now!" proposal makes a start in this direction by expanding MassHealth coverage for all adults to133% of the federal poverty limit and for parents and older adolescents up to 200% of the federal poverty limit, as well as creating an Adult Medical Security Plan up to 300% of the federal poverty limit.

Provide health benefits to state-contracted workers

Many workers who work for firms that derive the bulk of their income from state contracts are themselves uninsured. In a particular irony, this applies to the many home health workers and other providers of personal care services who are often without coverage. In seeking to expand coverage for the uninsured, the state should get its own house in order by requiring firms that do a certain minimum amount of business with the state to provide insurance to their workers by paying adequate rates to contractors to make it possible to provide health benefits.

Supporting the Infrastructure for Community Participation and Planning

In a system that falls far short of universal coverage, community participation is a crucial element to encourage and support. In Massachusetts we have a strong system of community coalitions and networks of outreach and enrollment workers. Community models that combine enrollment and outreach with a system of care for the uninsured, such as EcuHealth Care in North Adams, must be supported. The Health Access Networks and minigrants have been crucial components in the state's success in expanding coverage. They should be supported. The current community benefits process needs to be strengthened so that community groups have a seat at the table, are involved in the decision making process when priorities are being established, have resources to support community participation, and so that reasonable hospital and HMO resources are allocated to unmet community-identified needs.

Purchasing pools and risk adjustment

The Commonwealth should support formation of purchasing pools, perhaps through the manipulation of the existing tax subsidy for insurance (e.g. full deductibility would only

be available to firms that purchased insurance through an approved Pool). Pools would offer more choices to workers, and would also risk adjust payment to encourage plans to develop innovative approaches to provide more efficient and effective care delivery. Pools could also explicitly reward plans in purchasing decisions for addressing certain critical quality areas such as reducing medical errors, reducing ambulatory-sensitive, unnecessary hospitalizations, and reducing racial disparities in treatment.

Cost

Reduce prescription drug spending

Increased spending on prescription drugs is one of the most significant cost drivers underlying rising costs in both public and private coverage. To address this issue, a multi-pronged effort is needed.

- *Assess clinical effectiveness*

  Public and private payers should collaborate to create an independent body to clinically evaluate the effectiveness of new medications. This body would identify for whom new drugs represent a significant clinical advance. This would allow payers to make coverage and reimbursement decisions based on clinical and cost-effectiveness. In other words, if there were not evidence that a new drug is more effective than an old one for a particular condition, insurers would not pay more for the new drug. Exceptions could be made in cases where an older treatment is contraindicated.

- *Invest in provider education*

  Every year pharmaceutical companies invest millions of dollars to encourage physicians to use their products. A joint initiative by payers to promote education about clinical and cost effectiveness ("counter-detailing") would help foster prescribing patterns that were both higher quality and less expensive

- *Negotiate for lower prices*

  The Commonwealth should establish a statewide drug purchasing pool to negotiate deeper discounts from drug companies. By creating preferred access in Medicaid, the GIC, and Prescription Advantage to those drugs governed by supplemental discount or rebate agreements, the Commonwealth could reduce its own drug spending. At the same time, it could further increase its negotiating leverage, if it made drugs available to private purchasers at the discounted price.

Invest in public health

Reducing the incidence of illness is a critical and often overlooked cost-containment strategy, as well as a basic component of accessible, quality care.

- Smoking related illnesses are the largest source of preventable disease in the Commonwealth. Raising tobacco taxes not only provides critical revenue to support public coverage, it also reduces smoking and smoking-related illnesses. Continued investment in smoking cessation and prevention is also essential.

- Protecting and expanding investments in disease prevention programs, prenatal care and early intervention, community-based outreach, health education, school health, and other essential public health programs are also critical to reducing disease, addressing racial and ethnic disparities in health, and reducing costs such as unnecessary hospitalizations and emergency room use.

Refinance long-term care

The current system of long term care financing--where individuals play "Russian roulette", hoping not to incur major long term care expenses and then spend themselves into poverty and Medicaid eligibility, if they do need services-- should be replaced. A new system that broadly and predictably spreads what individuals and the state now pay while retaining Medicare and the federal share of Medicaid payments should be substituted. In exchange for contributing on a regular and predictable basis to the financing of long-term care, individuals would no longer be subjected to a spend-down.

Promote Affordable Insurance

Additional action is needed to enhance the affordability of coverage through a new public/ private partnership, especially in the small group and non-group markets. The state should act to make small group and non-group insurance more affordable by assuming a portion of the risk for the highest utilizers through a publicly supported reinsurance mechanism. Spreading the risk of catastrophic costs across the entire population would help bring down prices, and make it possible for more people to obtain and maintain coverage.

Institutional Stability

Continued exclusive reliance on the market will produce predictable results: more instability and contraction of services, and increasing barriers to care particularly for lower-income and sicker individuals. Chapter 141 of the Acts of 2000 created a mechanism to identify essential health services, but no real mechanism exists to preserve services once they have been identified. As such, Chapter 141, as important as it is, is like a one-legged stool. Although a return to a fully regulated system does not seem like a feasible option at this time, a number of initiatives should be implemented to promote institutional stability, ensure fair contracting, and promote both access and cost-effectiveness. In conjunction with improved real time data, which should be available to the state, the following mechanisms could be coordinated to provide not only crisis management, but on-going monitoring that would allow for action before institutions are in serious crisis.

Contract arbitration

Currently, some contract negotiations are too important to be allowed to break down and some involve entities with too much concentrated economic power to produce a fair outcome. In the world of organized labor, binding arbitration presents a means of breaking logjams when negotiations fail, and a breakdown is simply unacceptable (e.g. for reasons of public safety). A similar model applied to health care would leave the vast majority of negotiated agreements undisturbed, while providing an important safeguard for the public interest in those cases where the negotiating process fails. Negotiations involving an entity possessing significant market share should be subject to arbitration upon a showing by either party that a sufficient number of people would be affected by a failure to reach agreement and/ or that excessive market power was distorting the outcome.

Essential Services Preservation Board

Similar in some ways to the Acute Hospital Conversion Board, a board including the Commissioners of the Department of Medical Assistance, the Department of Public Health and Health Care Policy, the Division of Health Care Finance and Policy, and Division of Insurance should be established (with provider, payer and consumer representation). In the event of a finding by the Department of Public Health under Chapter 141 that some essential services are in danger of closing, the board would have authority to increase Medicaid rates and to access money from a revolving loan fund to help stabilize institutions, and to allow for the continued provision of services.

Hospital receivership

The state needs greater authority to intervene to protect financially troubled institutions, as is the situation with HMO's. Receivership should operate in conjunction with the Chapter 141 process and the Essential Services Preservation Board. Together these elements would help support essential services and financially troubled institutions.

Medicaid rates

Low rates of payment are of concern to providers. We have supported increased rates for dental services as part of a comprehensive solution to the problems facing Medicaid beneficiaries. As the state emerges from recession, attention must be paid to Medicaid hospital rates. However, as Medicaid rates increase, there should be some shift in the respective roles of Medicaid and the Uncompensated Care Pool in financing care for the uninsured. In exchange for higher Medicaid rates, providers (both hospitals and physicians) would incur some obligation to care for the uninsured without further reimbursement. Pool payments would supplement Medicaid where providers had exceeded this obligation or where Medicaid payments were already subject to Upper Payment Limits, and would not be adjusted further to help finance care for the uninsured.

Workforce Issues

The hospital workforce is an important part of a hospital's community. Fair dealings with employees, including a ban on union-busting activity, should be a condition of participation in the Medicaid program.

Fair Financing for Uncompensated Care

The Uncompensated Care Pool needs fair and adequate financing. Currently the burden of paying for the uninsured falls disproportionately on those who provide employment-based insurance—increasing the competitive disadvantage of those firms. At the same time, Pool financing is set at an arbitrary level reflecting neither changes in the number of uninsured nor the cost of providing care. A fair financing mechanism would seek to spread the cost of care for the uninsured as broadly as possible, not exempting employers who do not now offer coverage, and would adjust to reflect changes in health care costs and the size of the uninsured population.

Lahey CLINIC

David M. Barrett, M.D.
Chief Executive Officer
Chairman, Board of Governors

January 28, 2002

Honorable Herbert Wilkins
Executive Office of Health and
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Stuart Altman, Ph.D.
Sol C. Chaikin Professor of
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Brandeis University
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Waltham, MA 02454

Dear Justice Wilkins and Dr. Altman:

Thank you for your letter requesting input with respect to the Final Report of the Task Force. First, let me thank you for the outstanding efforts that you have contributed for the benefit of health care in the Commonwealth. We all truly appreciate your unswerving diligence.

We at Lahey believe that the efforts of the Task Force must continue, but in a different version. An independent organization similar to the Finance Committee should be perpetuated so that there is some consistent oversight of the health care industry in Massachusetts. We would hope that this organization would be somewhat independent of the legislature.

For example, the conclusions and recommendations of the Finance Committee with respect to the Medicaid program were very constructive. To have this ongoing effort cease would be most unfortunate. Also, once the Special Commission on the Uncompensated Care Pool issues its report, ongoing thorough review of the results of any reform will be essential.

Other issues which this proposed independent organization could explore include the following: 1) the disparity between costs and the amounts paid by private insurers in order to gauge better the extent of this problem and the resulting shortfall in payments by Medicaid; 2) the differences in bargaining power among hospitals (and hospital systems) with respect to managed care payments and the related adverse impact on competition; 3) the uneven distribution of employer-paid premiums among different providers for equal services; 4) the practice of the Commonwealth's special allocations to distressed hospitals, which are inefficient and unneeded from an access standpoint; 5) ways that government can help increase the supply of caregivers in critical areas so that salary scales are not distorted by providers with more abundant resources; and 6) the development of uniform quality and safety standards

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for the different categories of hospitals(community, teaching, and rural) and the establishment of a grants program to assist hospitals in satisfying these standards.

We are disappointed with the work of the Administrative Simplification Committee. Their recommendations did not adequately address the administrative burdens inherent in the current health care system. There is much to be accomplished in this area, and we would hope efforts could continue.

Data collection and analysis remain crucial. Again, we believe that the new organization described above would be a very useful vehicle to bring understandable and meaningful data to the attention of Massachusetts consumers.

We hope that these brief observations prove useful.

Sincerely yours,

David M. Barrett

David M. Barrett, M.D.

MASSACHUSETTS ASSOCIATION OF HEALTH PLANS

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February 11, 2002

Hon. Herbert Wilkins
Professor Stuart Altman
Executive Office of Health and Human Services
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Re: Governor's Blue Ribbon Health Care Task Force

Dear Judge Wilkins and Professor Altman,

On behalf of the Massachusetts Association of Health Plans (MAHP) and our member health plans, I commend you on the hard work and leadership you have shown over the past year leading the Health Care Finance Working Group of the Governor's Blue Ribbon Task Force. The draft final report reflects the thoughtful, deliberative and reasoned approach you have demonstrated throughout the process. I am writing now to highlight key issues that were raised in the draft report as well as to make recommendations on important issues that we believe should be addressed in the final report. I request that you incorporate this letter into the final report.

The Finance Work Group issued a Preliminary Report on Financial Conditions in the Insurance Market in September of 2000. That report included an overview of the market, identifying problem areas, causes and possible solutions. We believe that the preliminary report made several important recommendations that should be contained in the final report.

The double-digit increases in health care costs over the last two years are not sustainable. An approach to better control health care costs is essential to a thriving economic environment. We recognize this poses a significant challenge, yet nevertheless it must be done. We urge you to address the escalating costs of care in a way that will provide quality care and sustain the expansion of health care coverage made in recent years. Some steps to help achieve this follow:

First, MAHP strongly agrees with the Task Force recommendation that any new health care mandate, including mandated benefits and reporting requirements, be considered in light of the added administrative burden and likely premium increase. In addition, we

suggest this requirement be extended to any new legislative initiative that impacts health plans. Each new mandate, of which there are almost 30 currently pending in the legislature, would result in higher costs and therefore higher premiums for employers and employees and take away flexibility in health plan product design. The continuing increase in health care costs is a serious problem affecting everyone in our commonwealth. Mandated benefits further add to the financial burdens on employers and employees. The current recession has made this situation even worse. Given these circumstances, employers will be more inclined to pass these cost increases on to their employees or eliminate health insurance coverage from benefit packages altogether. In both scenarios, the number of uninsured would greatly increase. Other employers will opt to become self-insured, which would eliminate protections that are available under fully insured plans. While there are certainly other factors that lead to higher premiums, the cost of health care mandates is one factor that can be calculated and controlled.

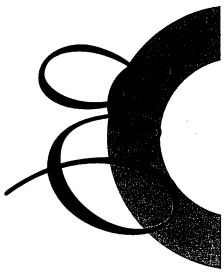
In order to help alleviate the continued increase in premiums, our member health plans are looking for ways to provide employers with lower cost alternatives for employee health insurance coverage. It is critical, however, that health plans have the flexibility to offer these types of products. Employers want to offer health insurance to their employees. But the coverage must be affordable. Health plans, when given the necessary flexibility, will design products that are affordable and provide consumers with ways to better manage their own health care expenses. While key elements of a health plan, such as the use of networks, coordination of care and the ability to control costs, would continue to exist, health plans will develop new products that promote safe, cost-effective and affordable care.

Another recommendation made in the draft report which MAHP supports is the adoption of the model, recommended by the National Association of Insurance Commissioners, for enacting minimum net worth and insolvency requirements. This will provide consumers and providers confidence in the financial soundness of the health plan.

Thank you for the opportunity to submit comments to be included as part of the final Task Force report. Please let me know if you need any additional information or have any questions.

Very truly yours

Marylou Buyse, M.D.
President



MASSACHUSETTS EXTENDED CARE FEDERATION

January 31, 2002

Professor Stuart Altman
Sol C. ChaikinProfessor of
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Waltham, MA 02454

The Honorable Herbert Wilkins
Executive Office of Health & Human Services
One Ashburton Place
Room 1109
Boston, MA 02108

Dear Professor Altman, Justice Wilkins, Members of the Health Care Task Force:

The Massachusetts Extended Care Federation (Federation), which represents 520 long-term care facilities caring for and employing more than 100,000 citizens of the Commonwealth, would like to respond to the **Final Draft Report to the Health Care Task Force from the Co-Chairs and Working Groups**, which was discussed at the January 28, 2002 meeting of the overall Task Force. We would appreciate it greatly if these comments could be attached to the final version of the report.

Before detailing our comments on the final report, we would like to thank the members of the Finance Working Group for the attention they have devoted to the issue of long-term care. We have had extensive discussions with members of the Working Group on these issues and appreciate the forum to discuss the very difficult challenges facing long-term care providers. The future of long-term care services in the Commonwealth should be a matter of the highest concern to consumers, providers, and policy makers alike.

While we consider the draft report to be a balanced, thoughtful document and concur with a number of its findings and recommendations in the area of long-term care services, we believe that it falls short in two major areas.

First, the final report fails to recognize the seriousness of the crisis currently facing nursing facility consumers and providers, or the urgent need to stabilize the system. To quote from the report, "Although access to nursing facility care appears to be adequate in most areas, occupancy rates in some regions are as high as 97%, and further closures in those areas **could** (our emphasis) lead to access problems." We believe that access to nursing facility care is already at crisis levels in many regions of the state. In the past three years, 76 nursing facilities with close to 5,000 beds have closed. In the18 month period during which the Health Care Task Force has been meeting, 40 facilities with 2,709 beds have been forced to close their

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doors. In the shorter patient stay, higher patient turnover environment of today's typical nursing facility, 97% occupancy is effectively **full** occupancy. The access crisis is not on its way; it is already here. Large regions of the state including Somerville-Cambridge, North Suburban Boston, Southeastern Massachusetts, and Franklin County have less than 100 empty nursing home beds. Virtually all other areas of the state are one facility closure away from having their own access crisis.

While the report recognizes that "financial conditions in the nursing home sector are serious," it does not convey the depth of the financial crisis, which is the worst we have seen in the 36 years since the development of Medicare and Medicaid. Once again, to quote from the report, "there is reason to hope that conditions are beginning to improve for some facilities...." The report then goes on to cite the emergence from bankruptcy of two large national chains as evidence of this improvement. What the narrative should have focused on instead is the information presented in Figure 4 of the final report, which shows that **solvent** nursing facility providers have had total profit margins at, slightly above, or slightly below zero for the past nine years. It is disingenuous, at best, to suggest that the nursing facility provider community is experiencing an improvement in its financial condition when its solvent facilities have barely broken even for the past decade. The financial infrastructure of the system is crumbling, and recognition of the depth of the problem is the first step toward framing appropriate and timely solutions.

The second major area where we believe the final report falls short is in its failure to recognize the primary role that chronic Medicaid underpayments have played in the nursing facility provider community's financial crisis. Once again quoting from the report, "Medicaid rates are not designed to yield a **cushion** (our emphasis) to subsidize significant changes in condition and **may** (our emphasis) be lower than the cost a given facility incurs in providing care." We believe this statement underestimates the gross inadequacy of Medicaid nursing facility rates along with its primary responsibility for the industry's financial instability. If an industry with three major payers is losing tens of millions of dollars, and one payer reimburses at cost (Medicare) while another payer reimburses above cost (private pay), it should be readily apparent to all that the third payer, Medicaid, is reimbursing providers at rates that are well below the true cost of care. In fact, the national accounting firm B.D.O. Seidman concluded that Massachusetts Medicaid nursing facility payment rates in 1999 were $15 a day below the actual cost of patient care, the third largest gap of any of the 36 reporting states. 2000 data indicate that the loss per day has increased to $16.50. Far from yielding a **cushion**, Medicaid nursing facility rates don't even cover the springs. We estimate that less than one out of every six nursing facilities receives Medicaid rates sufficient to cover the cost of care. By stating that Medicaid nursing facility rates on average **may** be lower than the cost of care rather than making the more accurate statement that Medicaid nursing facility rates **are** lower than the cost of care, the Finance Working Group missed an opportunity to advance the debate. The failure of the state Medicaid program to reimburse efficient nursing facility providers at rates of payment sufficient to cover the true cost of care is primarily responsible for the industry's financial crisis. No matter what kind of business you operate, if seven out of every ten of your customers pay less than your cost, you won't be in that business very long. The state should focus on ways to avoid the continued

closure of less expensive nursing facilities or it will find itself approving the construction of new, expensive nursing homes five or ten years from now when demand for beds fueled by an aging population begins to overwhelm bed supply.

Lastly, we would like to comment on the lack of response by the state to recommendations contained in the final draft of the report. The Finance Working Group recommended that four features of the current Medicaid rate methodology should be "re-examined." The draft final report correctly noted that just one of those four recommendations, changes to the total payment adjustment ceiling, was incorporated in the state's six-month (January 1, 2002 – June 30, 2002) nursing facility rate proposal. The other three recommendations were ignored entirely, producing a grossly inadequate plan that will raise median rates just 1.3% and lead, in our opinion, to wholesale facility closures and a deepening crisis in access to quality nursing facility care. We recognize that the Health Care Task Force has no authority or responsibility for implementing its policy recommendations, but we are saddened that the administration can encourage such a long, intensive effort at diagnosing the problem and then pay no attention at all to its treatment. One without the other is meaningless.

In light of the administration's refusal to reexamine the Medicaid rate changes referenced by the Finance Working Group as evidenced by its adoption of a six-month rate plan that continues to underfund nursing homes, the Federation has been forced to file a lawsuit in Suffolk Superior Court challenging the state's Medicaid nursing facility payment methodology. This action was not taken lightly. We have historically preferred to work with the state rather than litigate. But we have an obligation to our member nursing homes, their employees and their residents to advocate for quality nursing facility care. If the state chooses not to provide the resources required to provide quality nursing facility care, it must be held accountable for its actions.

The Federation appreciates the time and commitment that the Finance Working Group and the Health Care Task Force have devoted to long-term health care issues. While the challenges are daunting, there are steps that can be taken to stabilize the system so that our mothers and fathers (and ourselves for that matter) will have access to quality long term care services now and in the future. We stand ready to work with you further as you assemble and disseminate the final report.

Sincerely,

Abraham E. Morse
President
Massachusetts Extended Care Federation

W. Scott Plumb
Senior Vice President
Massachusetts Extended Care Federation

MHA

Massachusetts Hospital
Association

Ronald M. Hollander
President

February 13, 2002

Justice Herbert Wilkins
Professor Stuart Altman
Massachusetts Health Care Task Force
Executive Office of Health and Human
Services
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Dear Justice Wilkins and Professor Altman:

The Massachusetts Hospital Association (MHA) appreciates the work of the Governor's Health Care Task Force and its efforts to create a common understanding about the state of health in Massachusetts. We have carefully reviewed the Task Force's Draft Final Report. The Draft Report is an important step in the process of identifying our major problems, establishing specific goals, and achieving consensus on the need to move forward toward our common goal of ensuring that high quality, efficient health care is readily available to the all citizens of the Commonwealth.

We applaud the Draft Final Report for its recognition of many serious issues that the health care system is facing, including:

- the continuing financial crisis facing Massachusetts hospitals;
- the importance of our world class hospitals to our economy;
- the need for fair rates of payment by all payers;
- the need to evaluate the funding mechanism of the uncompensated care pool;
- the importance of adequate Medicaid payments to the financial health of hospitals;
- the rising cost of the inputs to health care services such as labor, prescription drugs, and technology; and.
- significant and growing labor shortages.

The Masssachusetts Hospital Association strongly supports the Draft Final Report recommendations that call for increased state funding for hospitals. We believe that the increase in Medicaid payment and uncompensated care pool reform called for in the report are essential to returning hospitals to financial health.

We do disagree with the Draft Final Report in some areas. A summary of our detailed comments is attached. We have a fundamental and serious disagreement with

characterization that the Massachusetts health care system is ". . . the most expensive in the world." Data in the report simply do not support this characterization.[1]

More fundamentally, the reference to Massachusetts health care expenditures per capita as 30% higher than the national average and higher than those of any other state, fails to recognize that these expenditures reflect economic *activity—not* the cost to our citizens. Much of that activity is actually an asset not a liability to the commonwealth. Literally billions of dollars in research and medical education flow into our economy each year as do payments from patients from other states and nations treated here in our world renowned and border hospitals. The relative costliness of health care to our citizens are better reflected in premium levels that are only about seven percent more than the national average, less than the difference in our household income levels. This is not to suggest that Massachusetts health care isn't expensive—excellent health care is not cheap. While we must take seriously the challenge to make the best use of every dollar spent[2], we shouldn't confuse costs with benefits when it comes to our health care system and our economy.

Throughout the 18 months of the Task Force's work, it became clear that the Commonwealth's health care system is in crisis: hospitals' financial situation is extremely fragile; critical shortages of caregivers are growing; and the capacity of today's system is stressed to the limit. The signs and symptoms of this crisis have been manifested in ambulance diversions, hospital closures, and the reduction or elimination of hospital programs and services. While the report properly notes the complexity of decision making in health care policy and the need to carefully set priorities, the recommendations represent a clear call to action to ensure that our hospital system maintains its financial and organizational strength. We strongly urge that policymakers in both state agencies and the legislature begin work immediately to implement the Task Force recommendations.

We must also continue and extend our efforts to address not just today's problems but the needs of the future. To meet community needs and expectations, the health care system must have sufficient capacity today and tomorrow; access to up to date technology; and the capacity to meet growing and changing needs, peak demands of disease cycles, and sudden demands caused by catastrophic events.

Under pressure from declining levels of payment, hospitals have restructured aggressively to reduce costs. In the ten years from 1990 - 2000, Massachusetts reduced the number of hospitals, beds, and utilization of inpatient services at greater than the national rate. There is now evidence that hospital capacity has been reduced to levels inadequate to meet growing needs. All of this is taking place in the context of increasing population-driven demand. Given what we know about the aging of the population, we are on a collision course of increasing need versus diminishing capacity – we must begin preparing now. Finally,

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[1] Figure 21 in the report shows that employee health care costs are higher in the several other localities.

[2] The draft report notes that several studies have found that Massachusetts hospitals are more efficient (after accounting for teaching and regional variation in input costs) than their peers. The Lewin Group found that Massachusetts Hospitals were 6% more efficient on average than their peers across the country, after adjusting for graduate medical education and other variables.

readiness for disasters, whether natural or manmade, is paramount as we look at capacity issues. The need to establish adequate stores, handle peak loads, and maintain the flexibility to respond to multiple possible scenarios requires reserve capacity.

We have welcomed the opportunity to work with the Task Force and Working Group members on these important issues. We urge that we move swiftly to turn the recommendations into action and to continue building a responsive, available and high quality health care system to meet the needs and expectations of all of our citizens.

Sincerely,

Ronald M. Hollander

MASSACHUSETTS HOSPITAL ASSOCIATION
Summary of Comments on Draft Health Care Task Force Final Report

Introduction

The following are a list of specific changes that we recommended be made to the Health Care Task Force Draft Final Report. In this review, for the most part, we limited our recommendations to changes that would clarify or correct statements, tie conclusions more strongly to underlying data, or shift or add emphasis. We did not include recommendations that go beyond the scope of the report as drafted.

Comments/Recommendations

Executive Summary

1. The draft report argued that a shift from community to teaching hospitals has been a major cause of cost increases. This does not appear to be supported by the available data. Analysis of AHA data from 1996-2000 (attached) shows that the distribution of services between community and teaching facilities in Massachusetts has been remarkably stable. There has been a decade long shift from inpatient to outpatient and a concomitant increase in the acuity and intensity of remaining inpatient care that would be expected to shift inpatient share to tertiary teaching institutions. In outpatient, there seems to have been a shift in total volume toward community hospitals even though the number of community hospitals has fallen faster than the number of teaching hospitals. There has been a slight reduction (-1.4%) in the community hospital share of hospital admissions. The distribution of emergency department visits has been essentially unchanged. We believe that state DHCFP data shows the same phenomenon.

DATA FROM AHA ANNUAL SURVEY DATABASE 1996-2000

ALL HOSPITALS	1996	%	1997	%	1998	%	1999	%	2000	%
Teaching										
Admissions	318086	40.6%	343820	42.1%	321481	40.8%	317756	40.4%	330085	41.4%
OP Visits	6275337	41.6%	5859399	39.3%	6214050	37.1%	6195211	36.5%	6998641	38.4%
ER Visits	761316	29.2%	731175	28.2%	765304	30.5%	793886	28.9%	815629	29.9%
Community										
Admissions	465460	59.4%	472369	57.9%	466663	59.2%	468863	59.6%	467125	58.6%
OP Visits	8819067	58.4%	9058431	60.7%	10553442	62.9%	10766800	63.5%	11209790	61.6%
ER Visits	1849957	70.8%	1864795	71.8%	1747805	69.5%	1949618	71.1%	1915542	70.1%
Statewide										
Admissions	783552		816189		788144		786619		797210	
OP Visits	15094404		14917830		16767492		15962011		18208431	
ER Visits	2611273		2595970		2513109		2743504		2731171	

We believe that the primary forces driving health care cost increases in Massachusetts are the same forces that the reports indicates are driving health care costs nationally: utilization of drugs,

technology, labor shortages, and demand (currently primarily for outpatient and emergency room services as shown in Figures 13 and 14).

2. There is no evidence that recent premium increases have resulted in private payers paying a higher percentage of costs than previously. First, the evidence is that premiums in other states have been increasing more quickly than premiums in Massachusetts. Second, there is evidence that premium increases have gone primarily to rebuild insurer reserves; relatively little has flowed through to providers in the form of increased rates.

3. We disagree that Medicaid rate increases will be self-defeating for providers. The current strategy of reducing the number of uninsured by increasing the number of citizens enrolled in Medicaid at grossly inadequate rates is far more destructive to the system. While increases in the uninsured could be of concern to providers, the appropriate compensating adjustment would be to ensure adequate funding of the free care pool, which is consistent with the Task Force's recommendation of fair payment rates by all payers.

Report

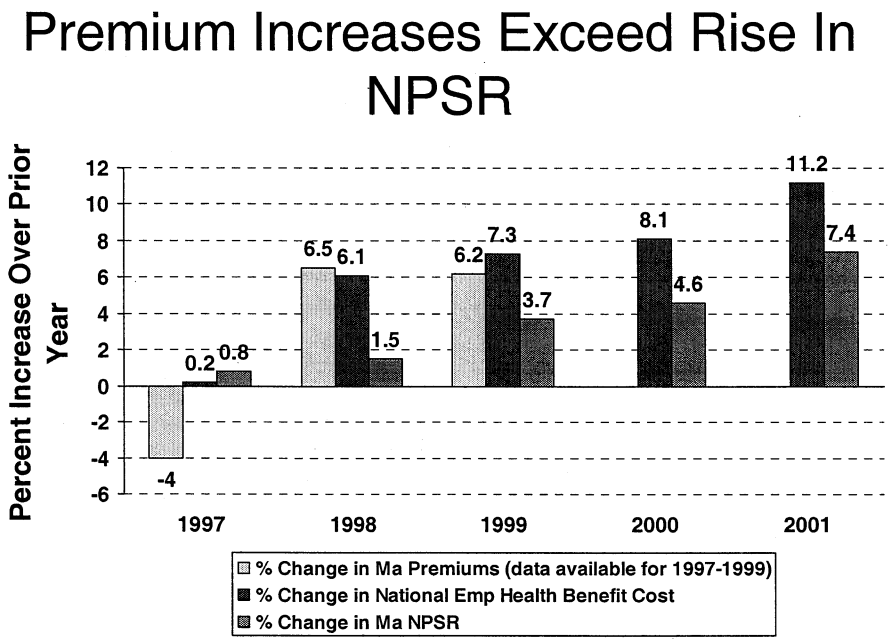
4. The draft report stated that Massachusetts health care expenditures per capita are 30% above the national average. The more relevant statistic, bearing more directly on the cost of the health care system to Massachusetts consumers, is the comparison of costs of premiums in Massachuasetts versus the national average. This data shows that Massachusettts health care premiums are not significantly higher than the national average. According to the U.S. Agency for Health Research and Quality, the average family premium in Massachusetts is getting closer to the U.S. average and was only 8.1% higher in 1999, before adjustment for the higher personal income and cost of living in Massachusetts. A DHCFP report in October 2000 showed that the difference in 1998 was 12%, also before adjustment (see Figure 18). The 2001 HMO Intercompany Survey by Milliman & Robertson showed that the unadjusted Massachusettts annual premium per member was 6.6% above the U.S. average.

5. The draft report stated that increasing Medicaid rates might relieve pressure on private payers to increase their rates. On the contrary, low Medicaid rates make private payers reluctant to increase their rates because they feel they are subsidizing Medicaid. Further, this contradicts the Task Force recommendation that every payer should pay a fair rate.

6. The draft report stated that the Work Group recommended financial assistance for hospitals in 10/00 and the state budget included both MA rate increases and targeted relief. While this is true, it is also true that the specific increases implemented were not meaningful. As shown in Figure 25, the FY01 and FY02 Medicaid cost adjustment factor was less than CPI-NE, the HCFA Market Basket and the Medicare Update Factor, and resulted in an increase in the Medicaid payment gap (a decrease in the Medicaid payment to cost ratio). Further, both payment method changes and targeted relief amounts were non-recurring.

7. The draft report noted that while health insurance premiums are going up, in general provider financial positions have not improved.

It is important to note the majority of premium increases have gone to build insurer reserves. The attached table shows that increases in Massachusetts hospital net revenue were substantially below average premium increases during the period 1997 - 1999. Figures 3 and 4 in the report show that insurer margins have significantly improved in 2000 and 2001 while hospitals margins have not. The following chart shows that increases in payments to hospitals have not kept pace with premium increases.



Ma Premium Data (Average Single Premium per enrolled employee) from Agency for Health Research and Quality; National Health Benefit Costs from William Mercer; NPSR data from DHCFP/MHA surveys

8. The list of recent changes in revenue streams should include 1) the implementation of a new Medicaid outpatient payment method based on APGs in 1998, which resulted in significantly reduced outpatient payments, and 2) changes in the Medicaid update factors which resulted in rate increases well below the rate of increase in costs (see Figure 25). Also, note the impact of Medicaid claims denials: "Not only are Massachusetts Medicaid hospital payment rates lower as a percentage of hospital cost of care than most other states in the union, but MassMedicaid also has a very high rate of claims rejection. In a recent study, DMA claims processing systems denied or suspended 46% of hospital inpatient claims and 25% of hospital outpatient claims. These rejection rates are unprecedented, and dramatically affect hospital cash flow from the state's Medicaid program, not to mention the paperwork load in hospital business offices. You have quotation marks here - what are you quoting? And you need to close the quote.

9. There are significant shortages in medical manpower in areas other than nursing. Reported vacancy rates in Massachusetts are above 10% for most categories of technicians.

10. One option for controlling health care costs should be reducing the paperwork demands through administrative simplification and carefully avoiding the addition of new reporting and data collection requirements without reducing other less important requirements. A recent AHA report

(are you going to attach this or just make reference to it? I'd just refer to it. shows that for every hour of patient care in America's hospitals healthcare workers must complete at least 30 minutes of paper work. It is even more in Massachusetts, where new reporting requirements have been added in finding patients eligible for uncompensated care, and for reporting a new data set on each visit to a hospital emergency department. Note that according to the AHA report, for each hour of patient care in an emergency room, an additional hour of paperwork is required on average throughout the nation.

10. The draft report stated that premium costs are decreasing relative to national average premium but that the differential on total costs has not decreased. These two numbers measure different things and that there is no reason why one would expect them to move in tandem. Total costs reflect demographic as well as cost trends, as reflect the growing percentage of elderly in the population. Total costs include all services, including long term care, medical education, and community based services, many of which are funded at least in part by the federal government, and therefore do not accurately reflect the cost burden on Massachusetts taxpayers. The comparison of Massachusetts to national insurance premiums (adjusted for income and cost of living) is the more relevant measure of our relative expense.

11. The draft report argued that increasing Medicaid rates would not stabilize the hospitals in most financial distress and would escalate costs. The discussion of Figure 20 states that an across the board Medicaid increase would help "financially robust" hospitals more than "distressed" hospitals. Neither of these arguments are accurate or appropriate. Merely being in the Highest Quartile in Figure 20 does not indicate financial strength. As Lewin described, margins in Massachusetts hospitals are well below the norms that are considered adequate for long term financial health. Further, the degree of benefit from across the board Medicaid increases is related directly to the volume of Medicaid services provided. It would not be reasonable to exclude high volume Medicaid providers from rate increases, as it would not be reasonable to exclude distressed hospitals on the grounds that the Medicaid increase would not in and of itself solve their financial problems. Across the board increases should be made as required by the fair payment policy supported by the Task Force. As the report states elsewhere, most members of the Finance Working Group share the view that Medicaid is not and should not be administered as a grant program where payments are based on need.

12. We disagree with the interpretation of Figure 3. A more accurate reading of the data shown in Figure 3 is: "While some hospitals have improved their financial condition, the industry remains in precarious financial condition with margins far below national medians. There are an alarming number of hospitals experiencing multiple years of losses. For teaching hospitals, not once in the last five years has the median operating margin risen into positive territory. Community hospitals have faired slightly better with positive median operating margins in '96 and '97 but negative margins in '98-'00. Again,you need to note what you're quoting and to close the quote .

13. With regard to the level of Medicaid payment, it is generally accepted that unless hospitals are paid more than their cost of care over time, they cannot remain viable. As The Lewin Group points out, in a state like Massachusetts where Medicaid, Medicare, and the private sector all pay less than costs (see Figure 1,) it is important that ***all*** payers pay at the cost level. The draft report discussion relates to

paying each hospital at its own cost which is not being proposed. The Lewin Report proposes payment at the average or standardized cost of care.

The Draft Final Report's discussion of Medicaid's outpatient payments is misleading because Medicaid's payment rates for hospital outpatient services on a service by service basis is no greater that payment rates for equivalent services in health centers or in many cases physician's offices – the question is whether these payment levels are adequate to meet the costs at any sites. But, for more complicated or intensive services not commonly offered by health centers or physician's offices, the payment rates are so low that they do not meet the costs of any provider, even the most efficient ones.

We disagree that hospitals are trying to steer patient away from other providers (for example, by purchasing community-based physician practices and/or employing community physicians directly). Most hospitals have tried various methods of steering Medicaid patients to other community providers but have been frustrated by their inability to do so – to the extent they have purchased physician practices it has been to maintain the physician in their community.

14. We disagree with the concept that it may be acceptable for the Medicaid program to pay less than the full cost of care provided to Medicaid enrollees as long as Medicaid payments are above the added costs (marginal cost) of providing services to Medicaid enrollees. It is one thing for a hospital to agree to marginal cost payments in a contract freely entered into with a purchaser that can promise increasing volume, but quite another for a public program with legal mandates for hospital participation to require hospitals to accept such payments. The only way such a public payment strategy could work without driving hospitals to financial disaster is if the state also mandates subsidies from other payers.

MASSACHUSETTS LEAGUE OF
COMMUNITY HEALTH CENTERS

Presented to

Governor's Task Force on Health Care Financing

by

Massachusetts League of Community Health Centers

January 28, 2002

Sustaining and Re-enforcing the Massachusetts Health Care Safety Net through Cost-effective Community Health Center Services

The following recommendations focus on how the Commonwealth can leverage the community health center network both to reduce system-wide costs and increase system-wide access to health care in Massachusetts. In order to engage the full potential of the health center system in meeting these fundamental goals, the Commonwealth must first address three related areas:

I. **Sustaining the community health center safety net during difficult economic times;**

II. **Building on community health center cost-effectiveness to lower overall system costs while maintaining or improving effectiveness of care; and**

III. **Increasing access not only to Medicaid recipients, but also to the growing number of persons affected by the current recession either through unemployment or reduction in employer-sponsored health insurance, as well as to the growing numbers of elderly poor.**

Background

Community health centers in Massachusetts are the foundation of the safety net of primary medical care for thousands of Massachusetts residents. Forty-nine community health centers provide services at over one hundred service sites across the Commonwealth. Of the forty-nine, thirty-three are independently licensed and sixteen operate under hospital licensure. Twenty-three, located in designated medically under-served areas (MUA) receive direct federal funding. These and six others are federally qualified health centers (FQHC). In

the past year, three new community health centers have been established in Fitchburg, Great Barrington, and on Cape Cod. With grants from the Commonwealth and federal assistance, fifteen centers have expanded or initiated dental services.

Community health centers are vital to the MassHealth Program. In total, health centers serve more than 250,000 MassHealth patients. These patients are members of Neighborhood Health Plan, the Primary Care Clinician Program, and other managed care organizations, including Boston HealthNet and Cambridge Network Health. Health centers also serve more than 250,000 uninsured and underinsured people. The balance of the health center patient population consists of patients covered by Medicare and commercial insurance for a total of 625,000 people (or one out of every ten persons in the Commonwealth).

In an August 2001 policy brief, the Division of Health Care Finance & Policy (DHCFP/Division) found that "Community health centers had a relatively low operating margin ranging from .3 percent to 1.4 percent during the 1994-1999 period. While is it not surprising that community health centers had low operating margins, the fact that they have decreased significantly since 1994 should be noted." In its conclusion, the Division found in part that "expenses incurred by community health centers grew faster than revenues during the five year period from 1994 through 1999, causing margins to decrease." The Division further stated: "This may have been due to funding sources which should keep pace with increases and expenses particularly for labor and technology. As a result, the level of debt incurred by community health centers increased during this period. While FY 1999 saw some recovery from 1994-1998, the level of debt incurred by community health centers nearly doubled." [1]

These findings directly support the conclusions reached in an analysis of audited financial statements for community health centers from 1995 to 1998.[2] Among other things, this report indicates that a majority of centers lost money on an operating basis in all years. An internal analysis based on FY 1999 audited reports indicates that 67 percent lost money on an operating basis and 29 percent lost money on a bottom line basis. Operating losses continued into FY 2000 at many health centers.

Community health centers have been major contributors to the success of the Commonwealth in providing access to high-quality cost-effective care for its poorest residents. Community health center services go far beyond conventional medical care delivery. Health centers reach out to and provide culturally responsive care to patients from a wide variety of backgrounds in over 15 languages. It has been well documented that every dollar invested in community health centers provides an average savings of three dollars to the overall health care system. Community health centers are poised to contribute even further by expanding urgent care and managing high-cost patient care, but only if the following changes are made to the state's current health policy. Without these adjustments, the health centers will be forced to reduce services, resulting in reduced access to health care for the most vulnerable in our state.

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[1] Financial Stability of Health Centers, Division of Health Care Finance & Policy, August 2001

[2] Massachusetts Community Health Centers in Crisis: Facts, Trends & Strategic Solutions for Investing in the Safety Net, 2000, Massachusetts League of Community Health Centers

I. Sustaining the Community Health Center Safety Net

The Commonwealth's community health center program is over 80 percent dependent on public resources. The average community health center patient mix is made up of Medicaid members (40-45 percent), Uncompensated Care Pool users (40-45 percent) and a combination of Medicare and privately insured patients. Neither of the first two payors is currently meeting health center costs.

In addition to their billable services, community health centers meet a long list of public health needs which in most states are provided directly by public health departments. Currently, all community health centers serve as vendors to the Department of Public Health (DPH) for programs including, but not limited to: primary health care, teen pregnancy prevention, maternal and infant health services, AIDS/HIV, substance abuse prevention and treatment, tobacco control, school based health services, dental care, and services for the homeless. Community health centers also are major providers of services to low income children and families covered by the Healthy Start program, the Children's Medical Security Plan, and CenterCare, a managed care program which serves 9,500 members at community health centers.

In order that the state's health care safety net be sustained, community health centers need the strong advocacy of the commission by inclusion of the following recommendations in its final report.

Medicaid Reimbursement

Primary Care Clinician Program Reimbursement: The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2001 (BIPA) requires state Medicaid agencies to reimburse community health centers according to a prospective payment system (PPS) or an acceptable alternative that recognizes the need for community health centers to recover their costs from Medicaid. In March 2001, the Commonwealth filed a State Plan Amendment with the Centers for Medicare and Medicaid Services (CMS) in which it agreed to take any necessary steps to comply with the federal law. The League is currently participating in a task force with representatives of the Division of Medical Assistance (DMA) and the DHCFP Rate Setting Commission (RSC). However, in spite of fact that the law's provisions are retroactive to January 1, 2001, no significant action has yet been taken.

→ **Resolution: We request the Commission recommend immediate implementation of BIPA PPS.**

Managed Care Reimbursement: Currently, three health plans, two public (Boston HealthNet and Cambridge Network Health) and one not-for-profit licensed HMO (Neighborhood Health Plan), provide the majority of MassHealth managed care. Both public plans have "disproportionate share" status. Under federal and state law, this status recognizes the added costs of serving publicly covered individuals and the importance of preserving access to services for them. The result is that community health centers receive adequate payments for members enrolled through these plans. However, these payments are not available for the almost 100,000 MassHealth members enrolled in Neighborhood Health Plan because, although Neighborhood Health Plan is a fully licensed HMO with over 90

percent of its members enrolled in MassHealth, it currently does not have disproportionate share status. State legislation was filed in October 2000 with the intent of providing a state basis for a disproportionate share designation for the Plan. This would not only provide needed resources for NHP, but is also expected to allow Medicaid to receive a higher share of Federal Financial Participation for Plan members. Both DMA and the Center for Medicare and Medicaid Services (CMS) have indicated their support for this position in the past.

→ **Resolution: We request the Commission recommend passage of HB 2167/SB 478, *An Act Increasing Access to Community Health Centers*, to the Legislature in their 2002 session.**

Uncompensated Care Pool Reimbursement

Community health centers are currently reimbursed for medically necessary services provided to low income uninsured and underinsured individuals through the Acute Hospital Uncompensated Care Pool under a methodology and rate structure established in 1995. Pool payments have not kept pace with the costs of serving the uninsured, the vast majority of whom are adults and therefore on average more expensive to treat than the Medicaid population, and are currently not even equivalent to Medicaid reimbursement. Uninsured poor patients are a growing population group served by health centers in their communities with dignity and cultural competence. Without this source of care these people and their families will have no other recourse other than to use already overburdened emergency rooms or to opt for no care at all. We are fully appreciative of the fact that Massachusetts recognizes the cost-savings and access-expansion capabilities of the health centers by reimbursing them for services to the uninsured. However, health centers are increasingly unable to fill the cost-reimbursement gap, particularly in face of steeply growing numbers of uninsured people using their services. Since 1991, when the health centers were first granted recognition under the Pool, the League has requested that their Pool reimbursement be equivalent to their Medicaid reimbursement.

→ **Resolution: We request the Commission's support for full cost reimbursement of community health center services to the low income uninsured, and that these changes be implemented immediately.**

Department of Public Health Funding

As noted above, community health centers provide a wide range of primary care and prevention services through grants and contracts from the Department of Public Health. Over the past five months, funding for these programs has been threatened, and in a number of cases slashed, and we understand that further cuts are planned in the FY 2003 State Budget. While we understand the need for fiscal prudence, these programs have been developed over the past twenty-five years not only to insure that those most in need receive basic services, but also because of a growing understanding of their cost-effectiveness. The results have justified this, making Massachusetts one of the foremost states in the nation in its response to a range of preventable problems, including infant mortality, AIDS/HIV, teen pregnancy prevention, tobacco and other substance control. Cutting these programs will prove to be short-sighted, and soon drive up the costs of treatment in other parts of the

system. In addition, these cuts will be compounded by the fact that DPH-funded programs receive Federal Financial Participation (FFP) while treatment services for more advanced disease do not.

→ **Resolution: We request the Commission resist the temptation to consider "preventive" synonymous with "optional," and to recommend that any reductions in DPH program funding not include services that generate FFP, or have the effect of driving up costs throughout the entire state health system.**

Strategic Financial Relief

In the conclusion of its above mentioned August 2001 issue brief, the DHCFP noted: "Much (community health center) grant funding is restricted and can only be used for certain expenses. This limits the flexibility of community health centers to subsidize losses in certain areas of operation with revenues in other areas." The League concurs with the Division's finding and further has found that without strategic financial assistance made available from the Commonwealth in FY 1999, 2000, and 2001, at least five centers would have gone into, or remained in bankruptcy, and many more health centers would have been in severe financial distress. Strategic relief also has laid the groundwork for the extensive improvements in health center information systems necessary to comply with state data requirements and prepare the way for HIPAA compliance and improved clinical management.

In FY 2000, community health centers received $4.9 million in hardship relief. This contributed to the release of one community health center from bankruptcy, and six others from either filing for bankruptcy or losing their DPH vendor qualifications. In FY 2001, $7 million was provided for a combination of hardship relief, information systems improvements, and strategies to improve access to hard to serve populations. In FY 2002, $7 million was again provided for the same purposes. As of January 14, 2002, letters of intent for $19 million have been filed by the community health centers.

Following is just one example of the positive impact of strategic relief grants on the state's most vulnerable health centers. Joseph M. Smith Community Health Center was $450,000 in debt at the end of FY 1999. The Allston-Brighton health center was on the brink of bankruptcy. Armed with an aggressive strategic plan to increase efficiencies and to find new financial resources was a start – but not enough. With an infusion of $741,000 in state relief funds in fiscal year 2000, the health center was on its way back. Its $450,000 deficit was immediately eliminated. The health center's computer system was upgraded, generating new efficiencies that previously had been out of reach. Dramatically, since that time, Joseph Smith has achieved a surplus position for the past two fiscal years: $24,000 in FY 2000 and $152,000 in FY 2001.

In addition to its return to solid financial footing, the health center has been able to expand services in the areas of prenatal care, case management and oral health. For example, between FY 2000 and FY 2002, the health center increased its dental provider FTEs from 2.7 to 4.8 As a result, dental visits rose 16 percent in the same year and are expected to increase by 36 percent in the current fiscal year.

→ **Resolution: We request the Commission to support the principle that funding for strategic relief, as well as for strategic investments in site expansion, information systems, and medical management technology be made available in the form of grants, loans, and fund development.**

II. Building on Community Health Center Cost-Effectiveness

Diminishing unnecessary emergency room use and preventable hospitalizations

In FY 2002, the Governor and House Budgets supported $5 million for "emergency room diversion," which the Senate Budget increased to $10 million. We understand that the principal reason that this did not survive the Conference process is that because of necessary state economies, it fell under a "no new program" decision rule.

To quote from the Finance Working Group's October 12, 2001 Draft Report: "It is well documented that hospitalizations for a wide range of conditions can be reduced or prevented through appropriate primary care. This report also documents reductions in ER visits. Individuals with lower household incomes are more likely to be admitted for a preventable hospitalization."

Preliminary results from the DHCFP's demonstration project at the Lynn Community Health Center indicate that case-managed primary care combined with pharmaceutical management under the center's Sec.340b Program have been successful in significantly reducing ER use. Several other efforts under way between community health centers and local hospitals as well as between community health centers and Neighborhood Health Plan show major decreases in ER use and hospitalization for asthma and other chronic conditions.

However, although diverting ER and primary care cases significantly decreases costs to the health care system, little of the saving is made available to meet the staffing, systems, and pharmacy costs that community health centers incur by doing so. In FY 2001, DMA instituted an after-hours urgent-care fee incentive which has been helpful in meeting these costs. There has been, however, little action on community health center requests for an after-hours urgent care incentive and changes to the pharmacy reimbursement formula which would make on-site pharmacy services feasible. More significantly, since services to 40 percent of community health center patients are reimbursed by the UCP, which does not provide any such incentives, requested changes to the Pool reimbursement methodology are essential in order for community health centers to continue to serve the uninsured.

→ **Resolution: We request the Commission to support: (1) Budget funding in an FY 2002 supplemental budget and in FY 2003 for increasing urgent care capacity at health centers (2) low interest loans and increased access to capital to complement funding and (3) recognition of reimbursement needs to meet the increasing demand for health center services by the uninsured.**

Statewide implementation of the Federally Qualified Health Center Section 340b Pharmacy Program

The Section 340b Drug Pricing Program, also known as the Veterans Drug Pricing Act, allows Federally Qualified Community Health Centers (FQHCs) to purchase pharmaceuticals at "Medicaid Best Price." Purchases may be made for distribution to patients by an on-site pharmacy or, if the center does not have a pharmacy, through a local pharmacy under contract with the community health center. In the latter case, all purchased pharmaceuticals are owned by the community health center. However, the program, as instituted by two community health centers with on-site pharmacies and two with contract pharmacies goes far beyond a simple purchasing program. In all cases, the center's Pharmacy & Therapeutics Committee has worked closely with a pharmacy consultant to develop a generically-biased recommended drug list, control access by pharmaceutical representatives, create an educational program for providers, and place control of samples and pharmaceuticals made available by "indigent drug programs" with the pharmacist.

DMA: Medicaid pharmacy reimbursement is equivalent to a retail price plus a $3 handling fee. However, because Medicaid loses its rebate on pharmaceuticals purchased by community health centers under 340b, it has set the policy of reimbursing the community health centers at cost plus the handling fee, which is inadequate for meeting the community health center costs. One community health center has developed a detailed proposal for a change in this policy under which Medicaid would still recognize savings while enabling the community health center pharmacy to meet its necessary costs.

DHCFP: At present, DHCFP reimburses on-site community health center pharmacy services at 25 percent of charges, and does not recognize off-site contracted pharmacy services. In the case of off-site contracted 340b services, while we recognize the Division's need for caution in limiting reimbursement for community health center services to those under the direct control of the health center, all 340b pharmaceuticals are owned by the community health center and dispensed only to community health center patients, with the pharmacist acting strictly as an agent. This adds a very tight degree of control, as well as a legal limit to the extent to which the Pool is exposed to paying non-included providers. We are hopeful that data developed regarding on-site services as well as information currently being gathered from the Division's demonstration projects will prove effective in changing the current methodology

→ **Resolution: We request the Commission to propose making the changes in DMA and DHCFP policy and regulation necessary for statewide implementation of the Federally Qualified Health Center Section 340b Pharmacy Program. We will be happy to share any financial and service information with interested members of the Commission.**

III. Increasing Access for Medicaid Members, the Uninsured, and Elderly Poor

With growing concern over challenges in the recruitment and retention of culturally competent clinical staff on the frontlines of the state's health care system, we are recommending that two additional steps be taken in the short term to maintain and improve access for vulnerable patients.

Workforce Development

Medical staff : Although the Commission's Finance Working Group, in its October 12, 2001 Report, cites that "it does not appear that there is any imminent shortage of physicians in Massachusetts nor are there widely reported problems in accessing physician services," it does concede that there may be possible exception in certain specialty and/or geographic areas and that physicians interviewed by the Finance Group felt that there may be a need for physicians on the "front line of medical practice to meet the demand for services." Had the Group met with a sample of health center physicians it would have been given a far more pessimistic picture. Health centers are located on the front lines, in under-served geographic areas, and serving hard-to-reach patients. Salaries at some health centers remain 25 percent below market for all levels of personnel and physicians, nurses (in particular given the current shortage), and dentists are increasingly difficult to hire. Waiting time for all services OB/GYN and dental care in particular are long and growing longer as demand increases and staffing becomes more challenging. League information indicates that most health centers are experiencing considerable and increasing difficulty in accessing specialty services for their patients. This is particularly severe when patients are uninsured and specialists are not on the teaching staff of certain hospitals. This could be easily corrected by allowing health centers to receive Pool reimbursement for care provided to health center patients by specialty care providers under contract to the health center.

Administrative staff: Paradoxically, the current economic recession provides a unique opportunity for community health centers to attract skilled administrative and multi-lingual workers who until recently found greater economic rewards in the transportation and hospitality industries. With the support of local community colleges and other career based schools, proposals are being developed for skills training and accelerated health career track programs for these potential employees.

In collaboration with the industry, the state can affect the future frontline health workforce by providing increased funding for state school tuition and fee assistance for administrative and clinical staff (including nurses) working in health centers.

Conclusion

As the state economy continues to contract, many more of our residents may be left without health insurance and with competing demands on marginal incomes. At the same time, the overall health system cannot absorb the additional costs of our failure to control spending by investing at one end of the system.

With the appropriate level of state reimbursement, strategic relief for building system capacity and investment in cost-effective models of care that result in lower hospital admissions, emergency room visits and specialty care utilization, Massachusetts community health centers are poised to assist the Commonwealth in managing the costs of the health system and maximizing access to care for the most vulnerable.

MASSACHUSETTS MEDICAL SOCIETY

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February 11, 2002

Dr. Stuart Altman and Justice Herbert Wilkins
Chairmen, Health Care Task Force
Executive Office of Health and Human Service
One Ashburton Place
Boston, Massachusetts 02108

Dear Dr. Altman and Justice Wilkins:

The physicians of the Massachusetts Medical Society would like to thank you, the Health Care Task Force and the Working Groups for the enormous effort you all made in putting together a comprehensive review of the health care system.

We would be most appreciative if you would consider appending these comments as an appendix to the Task Force Report.

Sincerely yours,

Francis X. Rockett

Francis X. Rockett, M.D.

TO: Professor Stuart Altman; Judge Herbert Wilkins
FROM: Francis X. Rockett, M.D., President, Massachusetts Medical Society
DATE: February 11, 2002
RE: Physicians and Physician Practice issues

The physicians of the Massachusetts Medical Society appreciate the hard work of the Task Force and the Working Groups for their comprehensive review of the health care system and specifically for their study of the issues facing physicians and physician practices in Massachusetts.

We support the underlying theme in the Task Force's Report for stabilizing our high quality health care system. We also realize that the Commonwealth's recent priority on public safety and the current challenges in our economy complicate efforts to accomplish this goal. However, we feel now more than ever, that we must all take bold and committed action to ensure continued access to care for our patients, especially those who are most vulnerable. As the representative of more than 17,000 physicians, residents and medical students, we believe that the stability of the Massachusetts health care system is dependent upon strong, viable physician practices.

We feel that the Task Force's recommendations recognize many of the health care systems inadequacies, but fall short of realizing that physicians face unprecedented challenges in maintaining their practices. Physicians are deeply committed to the well being of their patients, but we must also be concerned with covering our practice costs. Years of inadequate payments and overly complex regulations interfere with our ability to provide care the way we know it should delivered. The following comments address our concerns regarding the Task Force's recommendations.

Medicaid Payment Policies: We are gratified that the Task Force recognized the growing gap between the rising costs of providing care and the payments for that care from Medicaid. This cost/payment gap is unsustainable and currently pays 30% to 40% below Medicare for primary care and specialty services. As Medicaid covers an ever increasing percentage of patients in the Commonwealth and plays a more essential role in the Commonwealth's health care and social safety net, this differential continues to erode the financial stability of physician practices. We believe that equitable payment for all Medicaid physician services is in the best interest of our health care system. Targeted increases alone are not going to be effective when the entire system is in distress. While we support your recognition that we must maintain the stability of our world-class hospitals, we believe strongly that it is equally important to maintain the stability of our world-class physicians.

Another serious blow to many physicians and physician groups is the recent elimination of crossover payments for dually eligible Medicare/Medicaid patients. This action only compounds

the problem of already inadequate payments. We have significant concerns that implementation of these cuts will disproportionately affect those who provide care to elderly and disabled patients. This particularly targets and endangers the most vulnerable population in Massachusetts – indigent seniors who are permanent residents of nursing homes. We urge the Commonwealth to consider reinstating funding for co-insurance payments for dual enrollees in Medicare and Medicaid. Until the time that we find true solutions to the Medicaid system, we must not further cripple it by under-funding through elimination of crossover payments.

Given the reduction in payments from private payers, it is even more imperative that the state and other public revenue sources provide fair payments in order to maintain needed access to care for our patients.

Physician Workforce Issues: The Governor's Task Force Report acknowledged that certain specialties are experiencing shortages and that current supply figures do not reflect true physician availability. It is also critical to recognize that the factors creating shortages in anesthesiology, radiology, dermatology and child and adolescent psychiatry are not unique to these specialties; they are part of the experience of almost every specialty in Massachusetts and can lead to a shortage of physicians in the future if not addressed. A recent study by physician supply experts[1] found that that the US soon will be facing a shortage of physicians that will become progressively more severe.

A July 2001 Massachusetts Medical Society study found that 9% of physicians surveyed plan to leave the state because of the difficulties of this practice environment, 24% are planning on leaving the state if the environment worsens, and 41% said they were contemplating a career change or early retirement, for the same reasons.[2] This trend threatens our region's well-earned reputation for excellence and leadership in health care. One of the reasons for this excellence is precisely the phenomenon that makes a direct assessment of physician workforce numbers difficult, i.e., the high proportion of licensed physicians who are not full-time providers of care. In order to understand workforce issues, it is important to look closely at what physicians do, and not merely at the number of licensed physicians. Many physicians, who do not provide full time patient care, conduct research and teach, as well as provide part-time care for some patients.

Physician workforce issues are especially complex in Massachusetts because of our unique research and teaching environment. We have the most biotech firms per capita in the nation. Boston annually leads the nation in attracting federal dollars through NIH research grants. [3] Physicians provide a crucial role in maintaining this region's status as a center of excellence in medicine and research, and are a vital economic engine for this Commonwealth.

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[1] Cooper RA, Getzen TE, McKee HJ, Laud P. Economic and demographic trends signal an impending physician shortage. *Health Affairs*. 2002. 21(1): 140-154.
[2] MMS Physician Satisfaction Survey: May 2001. Available online at www.mms.org/pages/physiciansatisfaction.asp
[3] A Preliminary Analysis to Determine the Relationship Between the Supply of Physicians, Concentrations of Medical Facilities, and the Cost of Healthcare. James M. Howell, Ph.D., Christopher C. Ross, Neville S. Lee, Ph.D. May 2001. Available online at www.mms.org/pages/docsupply.asp

As the cost of maintaining physician practices has continued to rise in Massachusetts over the last several years, reimbursements do not meet these costs.[4] Physicians' income in Massachusetts continues to be among the lowest in the country, making it more difficult to retain and recruit physicians to Massachusetts, given our cost of living is among the highest. Initial results from our second physician satisfaction survey indicate that 45% of respondents are currently experiencing difficulty in filling physician vacancies, half of the respondents reported that there are shortages of physician specialties in their communities, and one-third of respondents are having difficulty retaining physicians. Maintaining top quality physicians in Massachusetts is critical to the sustaining the unique and highly respected medical environment in Massachusetts and deserves careful consideration.

Administrative Simplification: We are also grateful that the Task Force recognizes the increasing time physicians must spend on effective patient management, including paperwork, returning patient phone calls, and research. At the same time, most payment systems still rely on the number of patient encounters in order to generate any form of payment to physicians. With this increased activity and the fact that Medicare, Medicaid and private payers have failed to increase reimbursements as rapidly as practice costs have risen, we must reemphasize our concern that the health care system is failing to support the cost of our physician practices. Ultimately, this will impact access to care for our patients. We strongly endorse movement to simplify the complexity of health care claims processing. It is critical that such simplification results in a successful process for timely and correct payments for physicians, specifically within the MassHealth system.

Quality Initiatives: Physicians strongly support all appropriate efforts regarding quality improvement and patient safety. It is imperative however, that physicians not be faced with yet another unfunded mandate that puts further demands on their time without finding solutions to administrative burdens already in place. While we applaud the ideals of quality improvement, we recognize the complexities of medicine and must not be premature in imposing requirements. We heartily support the Task Force's recommendation to work collaboratively with all parties regarding quality initiatives. Such collaborations provide the best approach for achieving desired results.

In summary, we look forward to working with the leaders in the Commonwealth and the health care's key stakeholders to ensure the viability of our state's world-class medical environment. We continue to offer our resources and our commitment to achieving an affordable health care system that provides high quality care and access to care for all those seek it.

[4] MMS Physician Practice Index: July 2001. Available online at www.massmed.org/pages/mmsindex_report.asp.

MNA

Massachusetts Nurses Association

Massachusetts Nurses Association
Position Statement and Recommendations
The Massachusetts Health Care Task Force

Following review of the Massachusetts Health Care Task Force draft report, the Massachusetts Nurses Association is compelled to present our position statement and official recommendations to be included as a minority report and addendum to that final document.

The MNA represents 20,000 registered nurses and health care professionals in 51 Massachusetts hospitals, as well as a wide array of other health care settings, including VNA's, schools, long term care facilities, clinics and public health departments. Our members work on the front lines of the health care system, providing a real understanding of how the system works and, more importantly, given recent developments, how the system fails to work on behalf of patients and communities of the Commonwealth.

This document contains a statement of nursing's view of the health care system as it operates today; a discussion of our key concerns regarding the Task Force report, statement of core principles upon which we base our own position and recommendations, followed by the recommendations.

The health care system today: a failure of access and quality

From the perspective of nurses who work on the front-lines and spend more time with patients and their families than any other provider group, the Massachusetts health care system is a complete and utter failure on all counts: depriving access to those who need services and delivering inadequate to unsafe care to those who manage to obtain access. While structured with the goal of being economically efficient, our health care system is one of the most costly in the nation. Unless dramatic changes are made, it is a system with no prospect of emerging from its current crisis state; it is a system on the verge of total collapse.

The media headlines tell the story: emergency room diversions on the rise in every corner of the Commonwealth; closing of community hospitals like Waltham Hospital (not for lack of need, but for lack of a rational system of health care finance and resource allocation); more than 400,000 residents without health insurance coverage and thousands more underinsured; unsafe staffing levels and deplorable working conditions that are driving nurses and other providers out of health care altogether and endangering the lives of thousands of patients every day; skyrocketing prescription drug costs that leave seniors destitute or on a bus to Canada for drugs they need to maintain their health; and the closure of nursing homes and home care agencies further undercutting the health care safety net. This is the picture of the health care system today as seen by nurses and as experienced by patients.

The picture becomes bleaker still when one considers that we have an aging population in Massachusetts that will increase its demands on a system already in shambles. Add to this the specter of a growing recession, and with it the increases in morbidity and mortality that follow rising unemployment and economic hardship and it is clear that urgent and sweeping reforms are warranted.

MNA concerns about Task Force Report

Having reviewed the report, as well as heard the presentation and discussion of the report by the Task Force on January 28th, we were deeply concerned of the stance taken, both in the report, and supported by numerous verbal comments by task force members that "watchful waiting" by public policy makers is the best approach in dealing with our current health care crisis. Speaking from the perspective of caregivers struggling on the front lines, "watchful waiting" is the public policy equivalent of Emperor Nero's fiddling on the palace balcony while the City of Rome burns. While providing an excellent analysis of the financial state of the health care industry, there is little of value offered in the way of valid actions that might actually be taken to address the myriad problems confronting the system. While we watch and wait, the City of Waltham stands ready to lose its community hospital with 15 other hospitals teetering on the threshold of a similar fate. While we watch and wait, ER diversions continue to escalate, as hospitals strive to find the nurses needed to solve the problem, but cannot because nurses refuse to work in an unsafe practice environment. Hospitals throw precious resources away in the form of $2,500, $5,000 and $10,000 sign-on bonuses robbing nurses from one hospital to another while never addressing the retention issues. While we watch and wait, thousands of citizens go without access to adequate health insurance, or go underinsured. While we watch and wait, seniors struggle to make ends meet on fixed budgets, while their prescription drug costs skyrocket. This strategy may more appropriately be deemed watch and waste.

More specifically, the MNA is deeply concerned of how the report fails to acknowledge in a direct and forthright way the need to improve nurse staffing as a means of addressing three key areas focused on in the report, i.e., the problem of reducing medical errors, the problem with ER diversions and the issue of workplace shortages. This is interesting to us because at different points in the Task Force deliberations presentations were made that included specific recommendations to link nurse to patient ratios to these issues. For example, the workforce issues presented to the Task Force explicitly states nurse-to-patient ratios as a strategy. Additionally, when Dr. Lucian Leape made his presentation on the need to prevent medical errors, he identified the need for the system to deal with the issue of nursing patient assignments. And when the MNA met with subcommittees of the task force, we made this point quite forcefully. Yet there is scant attention to this issue. While we address this issue under our recommendation section of this report let us reiterate it here. Poor nurse staffing and unsafe nurse to patient ratios are a primary cause of ER diversions, medical errors and the current nursing shortage.

Most concerning and alarming of all is recommendations found on page 56 of the report, which deals with the issue of workplace shortages, specifically two of the paragraphs on that page which proposes an option for state intervention relative to "job-related strategies" and "influencing demand" for nurses. These paragraphs state:

> *Job-related strategies.* These efforts would focus on re-designing nursing and other direct care jobs to make them more attractive; improving working conditions generally; and building career ladders so that more direct-care jobs would lead to a professional development path.

Influencing demand. This type of intervention would involve changing the scope of practice of some kinds of workers so that tasks could be re-assigned, and in some cases the number of one type of professional as opposed to another could be reduced.

For those unfamiliar with this concept, what re-design and changes in scope of practice refers to is the "deskilling" the workforce; the process of replacing skilled, highly trained and state licensed registered nurses with unlicensed, lesser killed personnel who would receive their training and certification from individual institutions. It is also referred to as "institutional licensure." We need to warn the task force and any policy maker to give serious consideration before pursuing such an intervention. In fact, it was a series of efforts to pursue this deskilling over the last decade that has created the nursing shortage we now face. Consultant based strategy on work re-design attempted to mirror the manufacturing industry in health care. As nurses were forced to leave by layoffs while many others voluntarily left due to the resulting working conditions. It is the equivalent of saving money on air travel by allowing flight attendants to be trained by the airlines to fly the plane. If you don't want to take the MNA's word for it, listen to Leah L. Curtin, RN, FAAN, former editor of the Journal of Nursing Management and one of the nation's leading experts on nursing administration issues. In a recent article in the January issue of the *Journal of Clinical Systems Management,* she had this to say about the concept of changing the scope of practice for nurses:

> Institutional licensure pops up just about every time we have a nursing shortage. The gist of it is this: your employer trains you to perform certain tasks that the law currently restricts to registered nurses. The employer develops the curriculum, tests the learner, supervises practice and certifies or licenses the caregiver. Because the employees' newly learned skills are not 'marketable,' the employee is 'captive' – and thus the employer can ease the shortage of RNs (by preparing others to perform their functions), reduce costly turnover among nursing assistants, and cut expenses (aides – even institutionally licensed ones earn less than registered nurses). The problem with this glorious plan is that it has been proven – repeatedly – that it doesn't work!
>
> If the work to be done is patient care, then the data show that the best person to do the job is a well prepared nurse working in an empowered and respectful atmosphere…To put the matter in a nutshell, institutional licensure – with its attendant recruiting, training and licensing of minimally trained aides does not work – for patients, or for institutions (complications and recidivism cost the average 350-bed hospital about $12 million/year).
>
> What works? When nurses have a great place in which to practice, they stay. Patients receive safe – even quality – care. The best physicians are attracted to the institution because their patients get the best nursing care. And costs go down as turnover goes down, malpractice suits go down, and recidivism goes down. This is not rocket science, but common sense backed by mountains of research!

In 1996, Brigham & Women's Hospital wanted to implement such a practice. 83% of the nurses at that hospital voted to strike to oppose it and won. In the next three years, the MNA saw nine of its bargaining units take similar overwhelming strike votes over the same issue. We can guarantee that any effort by any policymaker to attempt to cut costs by replacing skilled

registered nurses with lesser qualified personnel would result in numerous strikes, an uproar in the nursing community and a worsening of the nursing shortage. We agree with Ms. Curtin, such a proposal is nonsense, and worse, it is dangerous. Frankly, we are very surprised that the authors of this report would go to such great pains to omit language dealing with the subject of improving nurses' staffing conditions, while blatantly proposing a policy condemned by past practice, all the research that has ever been done on the subject, and by any nurse who has ever practiced under such a ludicrous arrangement.

Statement of Principles that underpin and guide nurses' position on health care reform

There are four core principles that underpin and have guided our positions on this issue. They are:

1. We believe that universal access to quality health care is a basic human right of every member of our society and that the inability to guarantee that right is evidence of a failure of our society that must be addressed.

2. We believe the health care system in our state is in serious crisis and in need of dramatic and comprehensive reform to secure the right of access to health care for all.

3. We believe the free-market, deregulated and corporatized approach to the delivery of health care in the Commonwealth which has been embraced by the legislature and the executive branch for the last decade is an abject failure, and it is the primary cause of the crisis we now face.

4. Nurses, as the providers who spend the greatest amount of time with patients and families and who have the most experience in dealing with the outcomes of the current model of health care delivery in this state, can no longer morally or ethically accept incremental approaches to reform of this system; nor can we sit by while more consultants are hired and more task forces are formed to "study" these issues with no mandate to affect fundamental change.

While the Task Force was a laudable effort in recognition of the critical state of the Commonwealth's health care delivery system, the MNA, as an organization that has participated on the task force and followed its proceedings, fears there is little consensus or commitment by this body to meaningfully deal with the health care crisis on a long-term fundamental basis, which is so necessary at this time.

It may be that this commitment is lacking in large part due to the lack of consensus regarding the underlying core values of our health care system. Specifically, whether we are to view health care as a right and social responsibility (as the MNA believes) or rather, to view health care as a privilege and a commodity.

While there has been much rhetoric suggesting the former viewpoint, the current public policy stance has been to adopt the latter viewpoint with a clear promotion of business philosophy and "market competition" solutions to problems with social implications. Without fundamental agreement on the goal and definition of the core "values" of our health care system, there is little chance that meaningful long-term solutions will be found.

MNA Recommendations for Meaningful Health Care Reform

Given our reservations, the MNA would still offer one short-term recommendation that seems within the reach of the task force capabilities; a second long-term recommendation for the kind of reform most needed to restore our system to solvency, fairness and safety; and a third recommendation specific to the nursing profession and to the delivery of safe patient care.

Recommendation #1 (Short-Term) Single Health Care Administrator

We would suggest the creation of a "single administrator". This short-term measure could be implemented immediately, while more fundamental long-term solutions are developed. At a minimum, a pilot project should be constructed in one or more of the health service areas in which a number of payers exist (beyond Medicare and Medicaid, i.e. where there are a number of competing health plans serving as payers for services). The purpose of a single administrator is to provide efficiency in the coordination and management of the administration of health care from the point of approval for care (if relevant) to the payment for care to provider(s). This change would address the costly and confusing redundancy of documentation and paperwork for those operating and accessing the system. While not overly controversial, this also provides a first step of agreement regarding uniformity among and between insurers and providers.

Recommendation #2 Adoption of the Massachusetts Health Care Trust Legislation Calling for a Universal Single Payer System for Massachusetts

From our perspective, the current multi-payer, market-driven system of health care financing is inefficient, ineffective and unredeemable. In its place we support and endorse a system as envisioned under the Massachusetts Health Care Trust Bill (S.599/H.2165) currently before the Massachusetts legislature, which would guarantee every Massachusetts resident health care coverage by replacing the current patchwork of public and private health care plans with a uniform and comprehensive health plan. It creates a single public entity called the Health Care Trust to replace all the present public and private bureaucracies. The Trust, appointed by the Governor, will have representation from consumers, professionals and government. It will:

- Oversee the delivery of health care services to Massachusetts's residents, with emphasis on universality, rational and effective allocation of resources, preventive medicine and the need for health care choices to be made by provider and patient.

- Collect and disburse funds for the purpose of providing comprehensive health care for all residents of the Commonwealth. These funds will derive from current state and federal expenditures for medical care, additional public and private sources to be proposed by the Trust following completion of a study undertaken by the legislature and sales taxes on products that tend to increase health costs.

- Negotiate or set fair and reasonable methods and rates of compensation with providers of medical services and with health care facilities and approve capital expenditures in excess of $500,000.

Massachusetts spends more on health care than any other state in the U.S., yet over a million of our residents have no health insurance or are underinsured! We already spend enough on health care in the Commonwealth to provide quality care for all of our residents. Under this bill, money that currently goes to administrative costs such as paperwork, marketing and profits would be spent on providing care.

We currently pay for health care many times over. As taxpayers, we pay for the public programs that make up almost half of direct health care spending. We pay for tax subsidies for employers who offer health insurance, whether our own employer offers coverage or not. As individuals, if we get employer-based coverage, we pay our share of the premium, and, on average, earn about 20% less than we would otherwise in order to cover the employer's share. Then we pay cash out-of-pocket for co-pays and deductibles. Businesses and individuals who buy liability insurance (auto, homeowners, product) pay for health care coverage for the people hurt, regardless of whether those people already have coverage – only insurance companies benefit from this duplicative arrangement.

By replacing private dollars with public dollars and making funding of health care more equitable, most individuals and Massachusetts businesses would, on average, pay no more than they do now for health care. Coordinating funding through a single payer (Health Care Trust) will save enough in administrative costs to pay for the health care needs of all Massachusetts residents.

Recommendation #3 Regulate Nurse Staffing Levels in Order to Recruit and Retain Registered Nurses to Ensure Safe Patient Care

We respectfully believe that the Task Force may fail to address one of the most pressing problems of the health care system. Today in Massachusetts hospitalized patients must share their nurse with too many other patients. The problem of inadequate registered nurse staffing is having a negative impact on patient care and driving registered nurses away from the bedside.

Nursing traditionally has gone through cyclical but manageable shortages; however, the hospital and managed care industry in the 1990's have turned a normal shortage into a national crisis. Regrettably, this current shortage was predictable and avoidable.

Led by traditional industrial business consultants, the industry, through "re-design initiatives", laid-off nurses by the tens of thousands and then tried to transfer the science-based and professionally licensed work of the registered nurse to well-meaning but inadequately prepared and unlicensed personnel.

Thus the existing nursing workforce was deskilled while those remaining were left with a speed up bringing about such common work environments as short staffing and mandatory overtime. And as managed care limited hospital stays to only the sickest, the registered nurses remaining on staff after consultants such as American Practice Management (APM) and the Hunter Group departed town were now given more and sicker patients for whom to care. As staffing levels deteriorated, and the pressure of bigger patient caseloads mounted, many RNs left for safer and less stressful work.

At the same time that conditions are driving registered nurses away from the bedside, we know that the level of registered nursing care impacts patient outcomes.

Studies over the past two decades have clearly shown that the amount and quality of care provided by registered nurses is directly related to the length of stay, patient complications and patient satisfaction. A recent study conducted by the Harvard School of Public Health, of 5 million patient discharges found a "strong and consistent" link between nurse staffing levels and patient outcomes. As registered nurse staffing levels decrease, negative patient outcomes increase.

Perversely, the same forces that conspired to create today's nursing crisis are now busy promoting supposed solutions. Many hospitals are pushing large sign-on bonuses for RNs. They're also paying exorbitant fees to temporary staffing agencies and seeking government help with nursing school loan forgiveness and tuition reimbursement.

Those tactics, however, do not fix the structural problems behind the shortage. Sign-on bonuses simply increase the competition for a dwindling supply of nurses. Temporary staffing agencies sap hospital resources while becoming extremely wealthy in the process. And school financial incentives may get more students for the moment into nursing, but the new nurse on the job still confronts the intolerable working conditions that are driving older colleagues out of the profession. The result is new nurses are leaving the bedside within two years.

To fix this problem, our lawmakers are going to have to step in with government-enforced registered nurse staffing standards before we further endanger our families and the public health. A formula for the safe nurse-to-patient ratios must be imposed. Mandatory overtime should be eliminated except in cases of a government declared emergency. Medicare, Medicaid and HMO reimbursements must use their funding authority to target and require safe nurse staffing levels for the sake of patient care.

In order to improve patient care and retain and attract registered nurses in the profession, safe registered nurse staffing levels must be created and imposed through regulation.

The good news is Massachusetts has a unique opportunity. Because of the conditions only 1/4 of licensed registered nurses are practicing at the bedside now. More importantly, Massachusetts has the highest per capita nursing population in the nation. Unlike other states, we do not have a current shortage of nurses, we have a shortage of nurses who are willing to work under the staffing/working conditions this system imposes. National and international surveys of nurses who are considering leaving nursing because of these types of conditions have shown the vast majority would stay at the bedside or consider returning to the bedside if nurse staffing is improved. In Victoria, Australia, where nurse-to-patient staffing ratios were recently mandated, more than 2,100 nurses (13%) returned to the bedside in a matter of months. The state of California, like Massachusetts similarly afflicted with a decade of market driven health care, last week became the first state in the nation to announce mandated minimum nurse-to-patient ratios for all acute care hospitals as a means of protecting patients and ending the nursing shortage in their state. The news was met with overwhelming relief and optimism by its nursing workforce.

Nurses have always been the backbone of America's health system. As stated above, nurses are the providers who spend the greatest amount of time with patients, and according to recent research, when there are more registered nurses, lengths of hospital stay are shortened and costly complications are averted. They are needed now more than ever as our parents and grandparents age and the country faces these uncertain times of terrorist threats affecting the health and welfare of our nation.

Conclusion

It is clear to the nurses of Massachusetts that our health care system is broken and in need of a complete and drastic overhaul. Without a commitment to the provision of health care as a socially good and basic human right for all; without a complete revamping of how we finance and administer health care to ensure we provide this right to all of our citizens; and without a system of regulations to ensure that patients receive the attention and care they require to recover from illness and injury, thousands of our citizens will suffer and many will die. The MNA, and the thousands of nurses and health professionals we represent, call upon all stakeholders to the health care debate to join with us in seeing that we end this crisis and create a health care system that works for the betterment of our society.

Report by the Service Employees International Union to the Massachusetts Health Care Task Force

Summary

The "Free Market" has failed

For hospital workers and health caregivers, the time for "watchful waiting" is over. Limited tinkering with the health care system falls far short of what is needed to address the current crisis.

The decision by state government to abandon health care regulation to the so-called "free market" and the corporate "managed care" agenda has failed.

The health care crisis must be addressed by legislation that will control costs, cover everyone, and keep our precious hospitals and nursing homes open.

Costs have to be controlled

Health care revenues must be used more efficiently. Limits are needed on how much insurers can divert consumer's premium dollars for marketing, administrative surplus or profit.

The state's huge purchasing power should be used to reduce outpatient prescription drug costs and require drug makers to pay for prescription drugs for people who can't afford them.

Care must be provided to everyone

Universal health insurance coverage in Massachusetts would solve many of the state's current problems. The state must have the authority to simplify the collection and disbursement of health care funds.

Hospital and health maintenance organizations should be required to meet their "community benefits" obligations – preserving open access for all

Hospitals and nursing homes must remain open

Massachusetts's hospitals and nursing homes that are suffering financial distress need prompt – but targeted – state aid. Targeted financial relief is more fair, efficient, and affordable.

The state must also identify essential health care services needed to protect the public's health. Financially distressed hospitals and nursing homes should receive emergency short-term revenue if needed to stay open and continue to provide high-quality care.

The Attorney General should have the authority to put hospitals and nursing homes into receivership.

State money should be used for health care only

Health care workers are responding to the crisis by organizing unions to gain a voice and protect their right to provide quality care.

The money that supports our hospitals and nursing homes primarily comes from taxpayers through Medicare, Medicaid and other federal and state programs. All of a health care institution's income, no matter what source, should go to care. Interfering on paid time in something that by law is the employees' own decision is wrong.

If the health care industry expects to get help from taxpayers, then spending thousands of scarce health care dollars to campaign against hard working and underpaid employees should be strictly prohibited.

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SEIU Local 285 is a statewide union of health care workers and public employees with more than 12,000 members. The local union represents workers at more than 50 hospitals, health clinics, and nursing homes in Massachusetts.

Report by the Service Employees International Union to the Massachusetts Health Care Task Force

Submitted by Celia Wcislo, for the SEIU State Council
January 28, 2001

The Governor and key legislative leaders convened a special Health Care Task Force in June 2000 to conduct a comprehensive analysis of the problems facing the health care industry and make policy recommendations to the executive and legislative branches.[1]

While we applaud the efforts by the Governor and the legislature to address the serious health care crisis facing the Commonwealth, the time for "watchful waiting" is over. Sadly, the "Final Report to the Task Force" calls for very limited tinkering with our health care system. Its recommendations fall far short of what is needed to address the current crisis. Most significantly, none of the task force's proposals would change the Commonwealth's reliance on the so-called "free market" to continue to guide major health care policy decisions.

The 50-member task force is mainly composed of industry executives and policy insiders. While there are 26 industry CEO's and association leaders, there are only five representatives for consumers and health care employees on the entire task force.[2] Given the composition of the task force, it is no surprise that it was reluctant to embrace comprehensive health care reform solutions.

For the health care industry, the report proposed that the state:

- Encourage the movement of some services to lower cost settings and reduce capacity at some teaching hospitals.
- Create a new commission to continue to monitor the health care system and make recommendations about cost increases, access and efficiency.
- Increase the state Medicaid reimbursement rate.
- Establish a hospital reinsurance revolving loan fund.
- Consider reducing hospital obligations to the Uncompensated Care Pool and allowing some hospitals to use these funds to alleviate their shaky finances.[3]

The Failure of the "Free" Market

The facts of the crisis are well understood. Massachusetts' health care costs are 30 percent over the US national average.[4] Health insurance premiums are increasing at double-digit rates for two years in a row.[5] The state's largest HMO has barely recovered from being on the brink of financial ruin, while other insurers are continuing to experience major problems.[6] And one of the top hospital networks, CareGroup, is publicly disintegrating.

Even with several new state programs that have expanded insurance coverage and access during the last few years of economic prosperity, hundreds of thousands of residents without health insurance.[7] Now, as the economy worsens and unemployment increases, that progress may rapidly disappear.

One of the most telling examples of how the "free market" has failed is the closure and downsizing of many community hospitals and neighborhood clinics that often provide the most efficient and least expensive care. These closures are occurring while emergency rooms are so full that ambulance diversions are at an all time high throughout the region.[8]

For example, the South Boston Community Health Center recently announced its intention to close emergency/urgent care services that will result in more patients being treated at Boston Medical Center, where emergency services are much more expensive.

The decision by state government to abandon health care regulation to the so-called "free market" and the corporate "managed care" agenda has failed. It is time for our state's leaders and health care executives to face the fact that the health care crisis must be addressed by legislation that will control costs, cover everyone, and keep our hospitals and nursing homes open.

Fortunately, there are already a number of bills before the legislature, which if passed, would go a long way towards alleviating the hardship facing consumers, caregivers and providers. We urge lawmakers to act on the following proposals during this legislature session.

Costs have to be controlled.
We need immediate administrative simplification. The Task Force's "working group on administrative simplification" has recommended that the Commonwealth adopt electronic transaction systems and set new standards to encourage its partners to do likewise.[9]

However, much bolder action is needed. A recent research study showed that $3.6 billion could be saved by cutting insurance company red tape and an additional $1.6 billion more could be saved by cutting drug prices and inappropriate care.[10]

Step one would be to pass legislation currently before the General Court that would ensure more efficient use of health care revenues. It would guarantee that consumer' premium dollars would be spent on health care services and limit how much insurers could divert from care to marketing, administration surplus or profit.[11]

A second bill would use the state's huge purchasing power to reduce outpatient prescription drug costs by about 20 percent and require drug makers to contribute to a new fund to pay for prescription drugs for people who can't afford them.[12]

Care must be provided to everyone.
The enormous savings from administrative simplification would be enough to extend health care to every resident of the Commonwealth and make long overdue investments in public health and preventative medicine.[13] Yet in the current budget crisis, the Executive Office is advocating slashing many of the public health programs that keep future costs down by investment in prevention.

Sometimes the obvious is hardest to see. Universal health insurance coverage in Massachusetts would solve many of the current problems we have spent months trying to address. A bill

establishing a state health care trust fund currently before the legislature would guarantee health care coverage for everyone and give the state immediate authority to further simplify the collection and disbursement of health care funds.[14]

Another very important bill would strengthen public participation in making sure that hospital and health maintenance organizations are meeting their required "community benefits" obligations – preserving open access for all.[15]

We support a proposal to expand insurance coverage with an increase in the tobacco tax to help the most vulnerable low-income workers and further discourage smoking.[16]

Finally, the state's uncompensated care pool must be preserved while hospitals should be encouraged to identify patients eligible for other state health insurance programs.

Hospitals must remain open.

In 1980, Massachusetts had 110 acute care hospitals. Since then, 53 hospitals have closed – and the list of ailing hospitals keeps growing.[17] The deep cuts that have already been made are affecting the quality of care and jeopardizing health, especially in many poor and working class communities.

During the time of this Task Force, Hallmark Health closed Malden Hospital and tried to close Whidden Hospital in Everett. Haverhill's Hale Hospital nearly shut down, but was sold at the last minute to a for-profit chain.

CareGroup's recently announced closure of Deaconess-Waltham threatens to dump 20,000 emergency room visits on neighboring local hospitals, making the diversion crisis worse. Two more community hospitals – Deaconess-Glover and Deaconess-Nashoba – may soon be added to the list. It has also recommended closing scores of desperately needed psychiatric beds.

The "bottom line" for the CareGroup network has become only those health care services that are immediately profitable. And just like many corporate takeovers and consolidations that happen in steel or manufacturing, the "core" plants are fed by the smaller (i.e., community) hospitals, until they are milked dry, spun off or closed.

To remedy the problem, the hospital industry has proposed massive across-the-board increases in Medicaid payment rates.[18]

We oppose an across-the-board Medicaid increase because it would simply boost the surpluses of hospitals that already are making enough money, and it would not be sufficient to really help the financially distressed hospitals.[19] It would not prop up cost effective community hospitals, but would funnel money predominately to those networks controlled by teaching hospitals.

Instead, we propose prompt -- but targeted -- state aid to stabilize Massachusetts's acute hospitals that are suffering financial distress. Targeted financial relief is more fair, efficient, and affordable.

If targeted relief is to be administered responsibly, the state must regularly monitor changes in hospital capacity and identify the essential health care services needed to protect the public's health.

Legislation proposing to do this, called the Hospital Stabilization Bill, would set up an early warning system to identify financially distressed hospitals and provide emergency short-term revenue if needed to keep hospitals open and provide high-quality care.[20]

It would create a new hospital stabilization fund financed by assessments on hospitals (and their related corporations) that can afford to pay them.

The hospital stabilization fund would finance managerial and technical assistance to needed but distressed hospitals. It would also provide short-term emergency financial relief in the form of cash grants. These would help stabilize a needed but distressed hospital until the long-term financing reforms take hold.

Significantly, the bill would also establish provisions for the state to put hospitals into receivership.

Safe staffing

Working conditions in many hospitals and nursing homes are so bad that many caregivers have been driven out of the health and long-term care professions. Many of the shortage problems that exist today are directly related to the reluctance of licensed nurses and nursing assistants to practice in positions where they are inappropriately rushed through their caregiving responsibilities, assigned unsafe patient levels, and confronted by mandatory overtime.

Studies over the past two decades have shown that the level of care provided by nurses decreases the length of stay, decreases patient complications and increases patient satisfaction.

SEIU supports requiring hospitals and nursing homes to maintain specific staffing levels. Legislation has been filed to set up a process for health care advocates, nurses, and hospitals to collaboratively craft a nurse staffing plan and help alleviate the current nursing shortage. Each health care facility would be required to anticipate, design and adhere to a daily written staffing plan as required by patients or residents to maintain safety and to support nursing staff compliance with applicable professionally recognized standards of nursing practice.

Separate legislation has also been filed to require safe staffing ratios in long-term care facilities.[21]

State money should be used for health care only

It used to be that health professionals -- doctors, nurses and other caregivers -- made the key decisions about patient care. But in this era of "managed care," health maintenance organizations, insurance companies and corporate hospital chains are now making these decisions.

The consequences for patient care are profound. The less care a company provides, the more money it makes. While patients' premiums and fees are up, the time staffers are given to spend with each patient is down.

Throwing money at the problem is not the solution. When the legislature acted to shore up wages for Certified Nursing Assistants in the nursing home industry, earmarking revenues to homes that increased wages and training, the industry was overjoyed. But 63 out of 100 audited nursing homes failed to pass the money on to increase staffing or wages. Nearly half of monies given to those homes will have to be returned to the State.[22]

As one of the charts in the final Task Force report points out, the state has lost 2,800 more nursing home beds since this group started it's work. During that time, patient complaints have grown from between 40 to 75 every six months (1997-1999) to 120 to 215 (2000-2001). In short, more money, less beds, and three times the consumer complaints.

Combined with the budget cuts in hospitals and nursing homes brought on by the Balanced Budget Amendment of 1997, it has led to a deepening crisis in the quality of care and working conditions for caregivers.

That's why in unprecedented numbers, health care workers are responding by organizing unions to gain a voice and protect their right to provide quality care to their patients.

Unfortunately, many hospital and nursing home executives have responded by diverting scarce public dollars away from patient or resident care to pay for expensive management interference against caregivers when they organize to gain a voice at work.

Examples of employer interference at Carney Hospital and the Marion Manor Nursing Home for the Aged and Infirm illustrate the costs. At both institutions, when workers sought to form unions, managers spent public money to oppose workers having a voice, and took caregivers away from their responsibilities on paid time to convince them to vote against the union. According to research reports by SEIU, Carney Hospital spent about $273,000 and Marion Manor spent about $342,000 of taxpayer's money![23]

When employers conduct a negative campaign, it poisons the atmosphere in the health care facility and deprives workers of a fair choice. Just as importantly, a negative campaign distracts employees from providing quality care and wastes scarce public dollars.

Health care workers have filed legislation that would amend current laws to ensure that no public funds would be used to interfere in workers' freedom to choose a union in health care institutions.[24]

Most of the money that supports our hospitals and nursing homes comes from taxpayers through Medicare, Medicaid and other federal and state programs. All of an institution's income, no matter what source, should go to care. Using it to interfere on paid time in something that by law is the employees' own decision is wrong. If hospitals and nursing homes expect to get help from

taxpayers, then spending thousands of scarce health care dollars to campaign against their hard working and underpaid employees should be strictly prohibited.

Conclusion

The task force has overlooked another important source for solutions to the state's health care crisis. Our state's many vigorous health care reform organizations should be encouraged by lawmakers to play a major role in the reform process. They are working to preserve and improve health care quality in their communities. These groups, led by dedicated grassroots activists, are on the front lines of the fight for comprehensive solutions to the health care crisis.

Many of these grassroots organizations worked together to put major health care reforms on a statewide referendum ballot in the spring of 2000. However, after most of the proponents of the referendum reached a compromise with the legislature, a new law was passed that achieved four significant reforms. The new law:

- Requires hospitals to give notice, hold hearings and submit plans to assure access before making cuts in services
- Established a grievance board to help resolve health insurance disputes
- Required timely payments from insurance companies for hospital reimbursements
- Established an advisory committee to study consolidated health care financing and administrative simplification.[25]

When the legislature and the governor enacted these reforms, it gave us – and the people we represent – confidence that our government was prepared to act in the Commonwealth's best interest despite opposition from powerful special interest groups.

But clearly these reforms did not go far enough. The legislature must again overcome the power of special interests and act to meet the state's health care needs.

This report points out a number of realistic legislative proposals that should be given immediate and serious consideration. Failure to do so would invite us to again seek these much-needed reforms through the initiative process.

Legislative summaries of the bills cited in this report are available from SEIU Local 285. Call (617) 442-4100 ext. 139.

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[1] "Panel to plot overhaul of health care system," Boston Globe, May 2, 2000.
[2] Health Care Task Force membership, 12/13/00
[3] Draft Final Report to the Massachusetts Health Care Task Force, January 25, 2002.
[4] "Health care costs in state still 30% over US average," Boston Globe, October 3, 2000.
[5] "Spending on health care rises 7 percent," Boston Globe, January 8, 2002 and "Health coverage costs rising, Mass. HMOs cite soaring expenses," Boston Globe, September 15, 2000.
[6] "Harvard Pilgrim in receivership," Boston Globe, January 5, 2000. "HMO profits plunged in US in '99, report says," Boston Globe, April 27, 2000.
[7] A state survey in 2000 found that 365,000 residents were without health insurance. Officials expect that the next state survey will show an increase. "Spending on health care rises 7 percent," Boston Globe, January 8, 2002.
[8] "Increased ambulance detours reflect packed ERs," Boston Herald, December 23, 2000.

[9] Interim Report of the Administrative Simplification Working Group to the State Health Care Task Force, December 18, 2000

[10] Estimates from "Massachusetts Can Afford Health Care for All," by Alan Sager and Deborah Socolar, Access and Affordability Monitoring Project, Boston University School of Public Health, November 2, 2000.

[11] "An Act to Ensure the Efficient Use of Health Care Resources." Lead sponsor is Rep. Christine E. Canavan, (D – Brockton).

[12] "An Act to Reduce Outpatient Prescription Drug Costs and to Expand Coverage." Lead sponsor is Rep. Patricia Jehlen, (D – Somerville).

[13] "Massachusetts Can Afford Health Care for All," by Alan Sager and Deborah Socolar, Access and Affordability Monitoring Project, Boston University School of Public Health, November 2, 2000.

[14] Legislation establishing a "Massachusetts Health Care Trust." Lead sponsors are Sen. Robert Travaglini (D–East Boston) and Rep. Kevin Fitzgerald (D-Mission Hill).

[15] "An Act to Strengthen Public Participation in the Development and Monitoring of Hospital and Health Maintenance Organizations Community Benefits Obligations." Lead sponsors haven't been determined yet.

[16] "An Act Expanding Access to Health Care, Reducing Youth Smoking and the Use of Tobacco Products, and Improving the Public Health in the Commonwealth." Lead sponsors are Sen. Mark Montigny (D-Fall River) and Rep. Rachel Kaprielian (D-Watertown)

[17] Chart from "Final Report to the Task Force Report." Also see "Before It's Too Late: Why Hospital Closings are a Problem, Not a Solution, (Second Edition)," by Alan Sager and Deborah Socolar, Access and Affordability Monitoring Project, Boston University School of Public Health, June 2, 1997 and "Massachusetts Hospital Costs Per Person Have Risen Much Faster Than the National Average," by Alan Sager and Deborah Socolar, Access and Affordability Monitoring Project, Boston University School of Public Health, December 15, 1999.

[18] "For Bay State hospitals, the coming year is critical," Boston Business Journal, December 29, 2000.

[19] "Many Massachusetts Hospitals Have Financial Problems, And These Must Be Address, But An Across The Board Medicaid Rate Increase Is Not An Effective Or Affordable Solution," by Alan Sager and Deborah Socolar, Access and Affordability Monitoring Project, Boston University School of Public Health, December 18, 2000.

[20] Legislation establishing an "Acute Care Stabilization and Preservation Trust Fund." Lead sponsors are Representatives Emile Goguen (D- Fitchburg) and James Marzilli (D-Arlington).

[21] There are two major staffing bills. "An Act Relative to Sufficient Nurse Staffing to Ensure Safe Patient Care (H. 1186)" and "An Act to Require Nursing Home Corporations to Maintain Safe Staffing Levels (S. 579)."

[22] Division of Health Care Finance and Policy, Report to the Legislature, April 5, 2001.

[23] SEIU's reports documenting the waste of taxpayer health care dollars at Carney and Marian Manor are available to the public from SEIU Local 285.

[24] "An Act Relative to Health Care Finance and Policy." Lead sponsors have not been determined yet for the "Health Care Only" legislation.

[25] "Lawmakers, advocates craft health care bill," July 7, 2000. "State requires notice before hospital cuts," Boston Globe December 20, 2000. "Grievance board established for health insurance disputes," Boston Herald, December 20, 2000. "Nonprofit-to-for-profit hospital conversions drawing interest," Boston Business Journal, December 15, 2000.

Publication of this document approved by Philmore Anderson, State Purchasing Agent
Publication Number: 18753-158-500-8/02-5.00-C.R.
Printed on recycled paper.